



Orthopaedic Associates of Zanesville

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Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Family Dr. _____

HISTORY OF PRESENT CONDITION

Why are you seeing the doctor today? _____

Date problems/symptoms first appeared and/or date of injury _____

Have you had any previous treatment for this problem/injury prior to today's appointment (i.e., family doctor, emergency room, chiropractic, massotherapy, X-rays, bone scan, CT scan, MRI, lab work, EMG, NCV, etc.)? No _____ Yes _____ *If yes, please describe:* _____

Is today's condition a result of an accident? No _____ Yes _____

If "yes", please circle: **auto accident** **work accident** **other**

Who is responsible for the accident/injury? Please check and complete below:

Self and/or not applicable _____
Auto owner: self _____ other party _____
Property owner: self _____ other _____
Other *please describe:* _____

This problem/injury occurred while (check all that apply):

Bending	_____	Reaching	_____
Falling	_____	Squatting	_____
Hit by an object	_____	Twisting	_____
Lifting	_____	Unknown	_____
Pulling	_____	Other (describe)	_____
Pushing	_____		_____

The pain I have is located (please check all that apply):

Neck				Knee-Specify:	Rt	Lt	_____
Shoulder-Specify:	Rt	Lt	_____	Lower Leg-Specify:	Rt	Lt	_____
Upper arm-Specify:	Rt	Lt	_____	Ankle-Specify:	Rt	Lt	_____
Elbow-Specify:	Rt	Lt	_____	Heel-Specify:	Rt	Lt	_____
Forearm-Specify:	Rt	Lt	_____	Foot-Specify:	Rt	Lt	_____
Wrist-Specify:	Rt	Lt	_____	Toe(s)-Specify:	Rt	Lt	_____
Hand-Specify:	Rt	Lt	_____	Back (upper)			_____
Finger(s)-Specify:	Rt	Lt	_____	Back (middle)			_____
Hip-Specify:	Rt	Lt	_____	Back (lower)			_____
Thigh-Specify:	Rt	Lt	_____				
Other	_____						

On a scale of 0-10, the pain I have with this problem/injury averages _____
(Please fill in the blank with a number from 0 to 10, where 0=no pain and 10=the most severe pain).

