

Ventura Orthopedics

Instructions: This is a scanned document, Please fill in the circle O Do not use an X, check mark, or line

PATIENT INFORMATION

Patient Name:		Date:
DOB:	Height:	Weight
Referring Physician:		Primary Care Physician:

I. Did another doctor send you to this office for evaluation? Yes No
 Would you like your medical report sent to your other provider? Yes No
 If so, please list provider information: _____

II. Which side is affected? Right Left Bilateral
 Problem involves the: Shoulder Elbow Forearm Wrist Hand
 Finger Neck Hip Thigh Knee
 Leg Ankle Foot Toe Back

III. Was there an injury which you believe directly resulted in your symptoms? Yes No (If no, skip to IV.)
 If so, what is the date of injury: _____
 Is the injury work related? Yes No
 Is this the result of a motor vehicle accident? Yes No

IV: Please give an approximate time (date, month, or year) when the symptoms began: _____

V. Describe the injury and/or development of your problem: _____

VI. Have you sought medical treatment for this problem prior to this visit? Yes No
 If so, where: Emergency Room Urgent Care Physician's Office Other
 Name of care provider and/or facility who treated you: _____
 What kind of treatment was given? Brace/Splint Crutches Cast Therapy Chiropractic
 What medication was given? Narcotic (Vicodin, Codeine, etc) Anti-inflammatory (Advil, Motrin, etc)
 Muscle Relaxer (Flexeril, Soma, etc) Corticosteroid (Medrol Dosepak) Injection
 Other: _____

VII. Have you EVER had any of the following studies:

	Body Part	Month/Year
X-rays	<input type="radio"/> Yes <input type="radio"/> No	_____
CT Scan	<input type="radio"/> Yes <input type="radio"/> No	_____
MRI	<input type="radio"/> Yes <input type="radio"/> No	_____
Nerve Test	<input type="radio"/> Yes <input type="radio"/> No	_____
Arthrogram	<input type="radio"/> Yes <input type="radio"/> No	_____
Myleogram	<input type="radio"/> Yes <input type="radio"/> No	_____
Discogram	<input type="radio"/> Yes <input type="radio"/> No	_____

Have you had surgery on this body part? Yes No

Have you had symptoms or an injury to this area before? Yes No

If so, please describe: _____

Allergies

Are you allergic to any medications? Yes No If yes, please list: _____
 Are you allergic to food or environmental substances? Yes No If yes, please list: _____

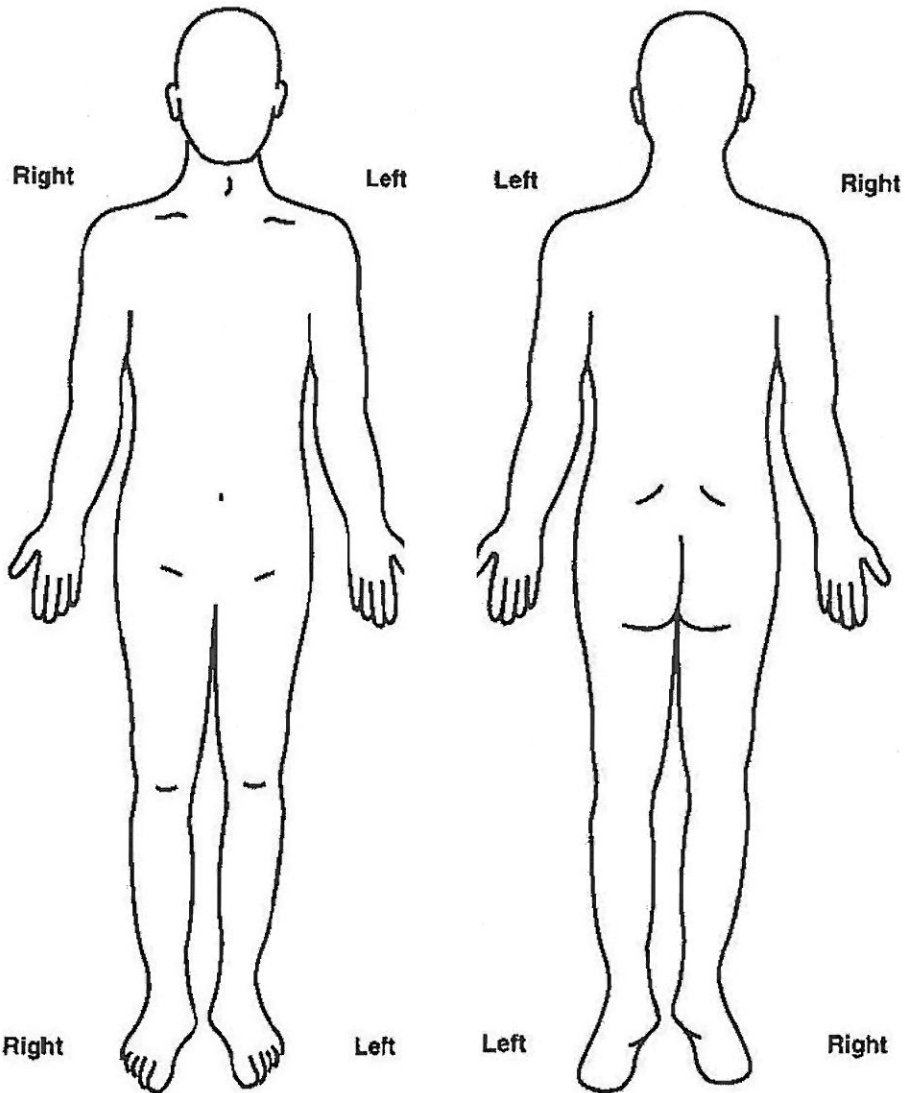
Medications (Please list name of medication and dosage)

Hospitalization (Please list)

Surgeries (Please list surgery type and year)

FRONT

BACK



Pain Diagram

Using the figures to the right, mark the areas where you feel the described sensation on your body. Use the appropriate symbols (indicated below) and include all affected areas.

- Ache** +++++
- Numbness** =====
- Pins & Needles** 0000000
- Burning** ^ ^ ^ ^ ^ ^ ^ ^
- Stabbing** //////

Patient Signature _____ Date _____