NORWICH ORTHOPEDIC GROUP, P.C.

Name: _____

Primary Care Doctor (Medical): _____

List any specialists you see: _____

Is there anyone you DO NOT want us to release personal information to?

B/P and pulse: _____

Height: _____

Weight: _____

B.M.I.: _____

MEDICAL/SURGICAL HISTORY	YES	NO
Any ALLERGY to medication, contrast dye, food? *(Record type of reactions)* _____ _____ _____	❑	❑
ALLERGY to LATEX	❑	❑
Cardiac / Vascular problems? *(if yes, circle)* Angina / Chest Pain — Heart Attack Heart Murmur — Mitral Valve Prolapse Irregular Rhythm — High Cholesterol High Blood Pressure — Poor Circulation Blood Clots (Phlebitis) Other_____	❑	❑
Pulmonary problems? *(if yes, circle)* COPD / Emphysema — Asthma Tuberculosis — Bronchitis / Pneumonia Sleep / Apnea Other_____	❑	❑
Abdominal problems? *(if yes, circle)* GERD / Reflux — Hiatal Hernia Gastritis/Ulcers — Abdominal Pain Colitis — Irritable Bowel Hepatitis / Jaundice — Cirrhosis Pancreatitis — Gallstones Other_____	❑	❑
Kidney or Bladder problems? *(if yes, circle)* Renal Insufficiency — Kidney Stones Recurrent Infection — Enlarged Prostate Kidney Transplant — Incontinence Other_____	❑	❑
Hormonal / Metabolic problems? *(if yes, circle)* Diabetes — Thyroid Disorder Anemia — Bleeding / Clotting Disorder Weight Loss Other_____	❑	❑
If female, pregnant? Date of last menstrual cycle?_____	❑	❑

	YES	NO
Neurological / Mental Health problems? *(if yes, circle)* Stroke — Seizures Multiple Sclerosis — Brain Injury Parkinson's Disease — Alzheimer's Disease Depression — Anxiety / Panic Attacks Other_____	❑	❑
Hearing or vision problems? *(if yes, circle)* Hearing loss — Visual loss Glaucoma — Cataracts Other_____	❑	❑
Infectious / Immune System problems? *(if yes, circle)* Cancer — HIV / AIDS Rheumatoid Arthritis — Lyme Disease Lupus — Fever/ Chills Other_____	❑	❑
Prosthesis/Implanted/External Devices? *(if yes, circle)* Pacemaker — Defibrillator Artificial Limb — Ostomy Electric Stimulator — Heart Valve Other_____	❑	❑
List all previous procedures & operations? _____ _____ _____		
SOCIAL HISTORY **Are you a smoker?** _____ # Packs/day	❑	❑
Alcohol use? *(please circle one)* None Rare Social Regular		
Do you use street or recreational drugs?	❑	❑
FAMILY HISTORY Cancer — Diabetes — Joint Disease Tuberculosis — Heart Disease — Disability High Blood Pressure Other_____		

List your current MEDICATIONS/ Include dosage and frequency /Include aspirin, anti-inflammatories, blood thinners, dietary supplements

Completed by patient? _____Yes *or Person Completing:* _____

Information reviewed by clinical staff: Date: Initials: Revised Date:

New Patient Intake Information

Norwich Orthopedic group, P.C. Rev. 03/2004

Age: ____

Your Hand Dominance: ❑ Right ❑ Left

Referred By ❑ Primary Care Physician
❑ Other Specialty physician
❑ Emergency Dept.
❑ Self ❑ Other source:

Referring Physician's name / location:

REASON for this visit:

❑ Work related injury Job Title:
❑ Motor vehicle collision Employer:

Symptoms present for: _____ days _____ months
_____ weeks _____ years

Date of Injury:

Describe onset of your symptoms:

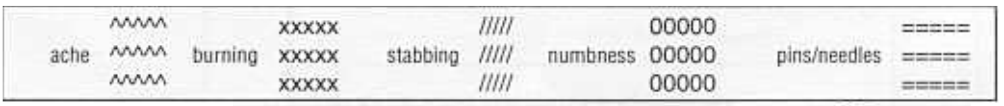
Prior history of problems with this region of your body:

Previous medical providers and interventions for this current problem:

Dr. & type of specialty	**diagnostic testing & results**	**treatments prescribed or attempted**
	❑ x-ray	❑ medications
	❑ Cat scan	❑ physical therapy
	❑ Bone scan	❑ manipulation/chiropractic
	❑ Myelogram/dye test	❑ injection
	❑ MRI	❑ surgery
	❑ Emg/nerve test	
	❑ Discogram	
	Other	

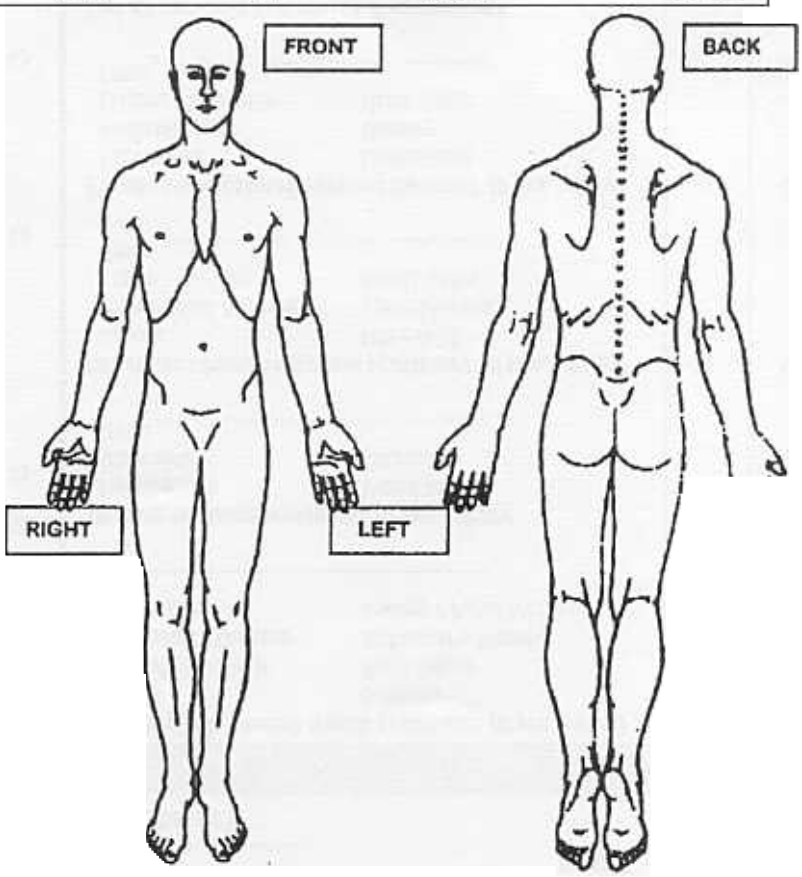
PAIN PATTERN Describe your current symptoms

Mark Location / Path of pain along your body:



Character/quality of pain:

constant: ❑ stable ❑ worsening
❑ comes & goes ❑ improving
❑ burning ❑ dull ache
❑ electric ❑ sharp, stabbing
Other;_____



Circle Intensity 0=no pain... max. imaginable pain=10
Today 0—1—2—3—4—5—6—7—8—9—10
"Good" days 0—1—2—3—4—5—6—7—8—9—10
"Bad" Days 0—1—2—3—4—5—6—7—8—9—10
minimal...mild...moderate...severe...incapacitating

Any numbness / pins & needles: ❑ none ❑ frequent
❑ rare ❑ constant

Aggravates symptoms:

❑ inactivity	❑ motion/activity	❑ sitting/driving
❑ arching back	❑ reaching overhead	❑ arising sit to stand
❑ standing	❑ looking overhead	❑ stooping/forward bending
❑ walking	❑ down stairs	❑ twisting/rotating
❑ laying flat	❑ up stairs	❑ coughing/sneezing
❑ worse @ night	❑ worse @ morning	❑ worse @ end of day

Lessens symptoms:

❑ inactivity	❑ motion/activity	❑ sitting/driving
❑ arching back	❑ stretching	❑ arising sit to stand
❑ standing	❑ heat	❑ stooping/forward bending
❑ walking	❑ cold	❑ twisting/rotating
❑ laying flat		❑ medications

Functions unable to do because of this problem :

❑ work	❑ driving/sitting	❑ lift/carry
❑ walking	❑ stair climbing	❑ sports/exercise/fun
❑ house chores	❑ yard work	❑ childcare
❑ upper body dressing		❑ grooming
❑ lower body dressing	❑ sleep	❑ sexual activity

❑ toileting ❑ Control problems or urine or stool ❑ yes ❑ no