Parkcrest Orthopedics, LLC: Patient Health History Information

Please complete this form entirely.

Name: _____ Today's Date ____/____/____

Date of Birth: _____/_____/_____ Age: _____ Height: _____ft _____in Weight: _____lbs

Family Doctor: _____ Referred By: _____

What are you being seen for today?

O Shoulder	O Right	O Left	O Calf	O Right	O Left
O Elbow	O Right	O Left	O Ankle	O Right	O Left
O Wrist	O Right	O Left	O Foot	O Right	O Left
O Tib/Fib	O Right	O Left	O Toe	O Right	O Left
O Knee	O Right	O Left	O Finger	O Right	O Left
O Hip	O Right	O Left	O Back		
O Hand	O Right	O Left	O Neck		

When did your pain/problem start? _____/_____/_____ **Were you hurt at work?** O Yes O No

How did your pain/problem start? O Injury O Spontaneous O Chronic

Are you currently working: O Full Duty O Light Duty O Off Work

Please describe your pain/problem:

_____

_____

_____

What treatments have you had so far?

O None	O Physical Therapy	O Surgery
O Narcotic Medication	O Massage or Ultrasound	O Traction
O Braces	O Manipulation/Chiropractic	O Visco Supplementation
O Cortisone Injection	O Anti-Inflammatory Medication	

What tests have you had to evaluate your problem:

O Xrays	O Bone Scan	O MRI Scan
O CT Scan	O EMG/Nerve Conduction	O Other: _____
O Blood Work/Labs	O Venous Doppler Study	

Please list ALL of you current medications and dosage:

_____

_____

_____

_____

_____

Immunizations: Flu Injection O Yes O No Date: _____

Pneumonia Injection O Yes O No Date: _____