

ADVANCED ORTHOPEDICS INJURY INFORMATION

For Office Use Only

Medical Chart Number: _____

Physician: _____

Date _____ Referring Physician _____

Last Name _____ First name _____ Date of Birth _____

1. WHAT IS YOUR INJURY:

- | | |
|--|---|
| <input type="checkbox"/> Shoulder ____ Right ____ Left
Are you right or left handed? ____ Right ____ Left
<input type="checkbox"/> Knee ____ Right ____ Left
<input type="checkbox"/> Other _____ (please specify area) ____ Right ____ Left
a) Date of injury _____ | b) Was your injury triggered by (check all that apply)?
<input type="checkbox"/> Sport _____
<input type="checkbox"/> Daily Activity _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> No specific trigger can be identified
c) How long of you been feeling pain? _____ |
|--|---|

2. SYMPTOMS

Shoulder (check all that apply)

- Pain (check intensity): ____ Mild ____ Moderate ____ Severe
 When does the pain occur? (e.g., activity, night, etc) _____
- Swelling (check intensity): ____ Immediate (less than 4 hours) ____ Delayed ____ Recurring
- Dislocation – Has this happened before? ____ Yes ____ No
- Weakness
- Is motion restricted? ____ Yes ____ No
- Other _____

Knee (check all that apply)

- Pain (check intensity): ____ Mild ____ Moderate ____ Severe
 When does the pain occur? (e.g., activity, night, etc) _____
- Swelling (check intensity): ____ Immediate (less than 4 hours) ____ Delayed ____ Recurring
- Pop/snap in knee
- Locking/unable to bend or straighten properly
- Kneecap unstable
- Difficulty with stairs
- Difficulty entering or leaving car
- Other _____

Other – please specify area _____ (check all that apply)

- Pain (check intensity): ____ Mild ____ Moderate ____ Severe
 When does the pain occur? (e.g., activity, night, etc) _____
- Swelling (check intensity): ____ Immediate (less than 4 hours) ____ Delayed ____ Recurring
- Unstable sensation / looseness
- Popping or “catch” in joint
- Other _____

3. TREATMENT (check all that apply and provide details)

- | | |
|--|---|
| <input type="checkbox"/> None/Rest _____
<input type="checkbox"/> Brace/Cast _____
<input type="checkbox"/> Anti-inflammatory/Medications (for this injury - e.g. Aleve, Advil) _____
_____ | <input type="checkbox"/> Injection _____
<input type="checkbox"/> Rehabilitation/Therapy _____
<input type="checkbox"/> Surgery _____
<input type="checkbox"/> Return to Activity (& Date) _____ |
|--|---|

4. ACTIVITY

- | | |
|---|--|
| a) Primary sport _____
b) What level? (e.g., college, recreational) _____
c) Other sports _____ | d) Runner? ____ miles x ____ days/week = ____ miles/week
e) How does injury affect your daily activities? _____ |
|---|--|

5. OCCUPATION

- a) What is your profession? _____
- b) What is your job description? _____
- c) How has your injury affect your job? _____
- _____
- _____