

Taos Orthopaedic Institute Orthopaedic Initial History Survey

Date: _____ Medical Record # _____

Patient Name _____ Age _____ Female Male

Height _____ Weight _____ Pulse _____ Saturation _____

Consulting Physician? _____

What is the main reason for this visit? Pain Numbness Weakness Other _____ (Chief Complaint)

Did you bring x-rays/MRI? Yes No

How long has this problem been present? _____ **Days** **Weeks** **Months**

What body part is involved?						
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L

Check the box which best fits how your problem started.

Then answer the one question below the box you checked. Use as much space to the right as needed.

NO INJURY (Onset was: Gradual or Sudden)

ANSWER:

Why do you think it started?

INJURY—(NOT AUTO OR WORK)

Date _____. Where and How did it happen?

INJURY AT WORK

Date _____. Where and How did it happen?

WORK RELATED—(BUT NO INJURY)

Date _____. How did your job cause this problem?

AUTO ACCIDENT

Date _____. Where and How was your car hit?

Please check the box below which best describes your problem:

The pain is Constant Comes and goes (Intermittent)

(Duration)

Severity of pain Mild Moderate Severe Extremely severe

(Severity)

What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning Other _____ **(Quality)**

Are there **associated symptoms?** Swelling Numbness Weakness

(Assoc. Symp)

Since my problem started, it is: Getting better Getting worse Unchanged

(Context)

Does your pain wake you from sleep? Yes No

(Timing)

What makes your symptoms **worse?** Activity Exercise Work Other _____

(Modify)

Which make you feel **better?** Rest Heat Ice Elevation Other _____

(Modify)

What medications have you taken or been prescribed for this problem? _____

(Modify)

Check which treatments you have tried:

Injection Yes No **Brace** Yes No **Therapy** Yes No **Cane/Crutch** Yes No

(Modify)

Provider Name _____ **Provider Signature** _____