Center of Orthopaedic & Rehab Excellence

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Patient Name_____ D.O.B._____ Chart#_____

IF REFERRED BY A PHYSICIAN, PHYSICIAN NAME_____CITY_____

IF REFERRED BY HOSPITAL, WHICH ONE_____DATE SEEN @ HOSPITAL_____

Body Part(s) Injured_____ RT_____ LT_____ BOTH_____

DATE of INJURY/ACCIDENT _____ Work Related _____ Employer_____

Description of Accident/Injury_____

Where did Accident occur? _____

If **Motor Vehicle Accident**, what **State** did Accident occur? _____

List any diagnostic studies for this condition such as MRI, Bone Scan, X-RAY's: _____

Xray_____ Where performed _____ Date of Xray _____

MRI_____ Where performed _____ Date of MRI _____

Bone Scan_____ Where performed _____ Date of Scan _____

CT Scan_____ Where performed _____ Date of CT _____

List **ALL Current Medications** (Ibuprofen, Tylenol, Aleve, etc)

Over The Counter_____

Rx_____ Prescribing Physician_____

Rx_____ Prescribing Physician_____

Rx_____ Prescribing Physician_____

Home Therapy Programs tried_____ When _____

If Outpatient Physical Therapy Where_____ When_____

List Any **Orthopaedic Surgeries** and **Dates *since your last visit***:

_____

Patients Signature_____Relationship (if **not** patient)_____Date_____