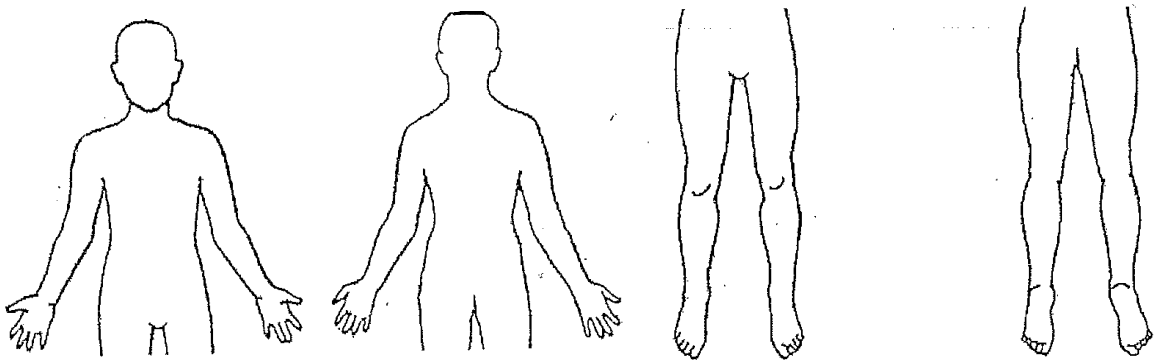
Dr. Kelly New Patient Form

History:

How long has it been bothering you? ___ days ___ weeks ___ months ___ years

How did it start? Sports injury ___ Work injury ___ Car accident ___ Fall ___ Overuse ___ Other ___ Unknown ___

Circle the area where you are experiencing pain:



FRONT BACK FRONT BACK

Is the pain: Sharp ___ Dull___ Shooting ___Other (explain) _____

How severe is the pain at its best and worst? (0 = no pain - 10 = worst pain imaginable)
Best ___ Worst ___

Any associated symptoms? Numbness ___ Tingling ___ Weakness ___ Night pain ___ Clicking ___ Popping ___ Buckling ___ Locking ___

Anything that makes it better? _____

Anything that makes it worse? _____

Have you ever had this (or a similar) problem before? _____

Previous Treatment:

Heat/ice ___ Creams/sprays___ Medications ___ Sling ___ Brace ___ Splint ___ Physical therapy ___ Injection ___ Testing ___ Surgery ___

Have you ever seen another physician for this problem? _____ If so, who? _____

Goals for Appointment:

Find a diagnosis ___ Make sure not causing damage ___ Fix the problem ___ Injection ___ Schedule surgery ___ Second opinion ___ Worker's compensation ___ Other _____

Name:_____ **Appointment Date:**_____