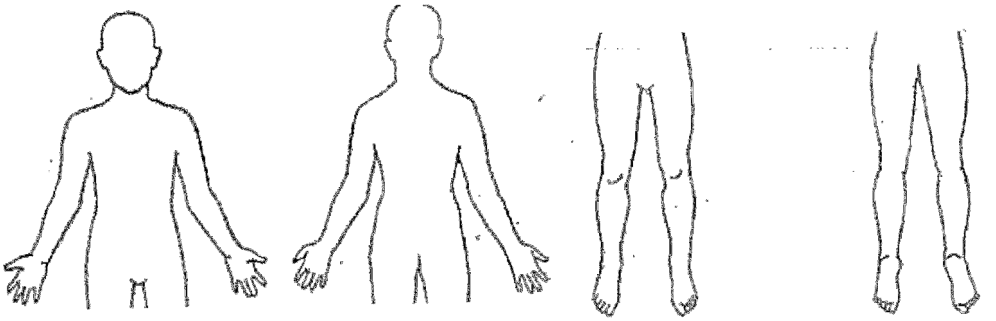
Dr. Kelly New Patient Form

History:

How long has it been bothering you (circle one)? # _____ days weeks months years
Date of injury (if applies): _____

How did it start (circle one)? Sports injury Work injury Car accident Fall Overuse Other _____

Circle the area where you are experiencing pain:



FRONT BACK FRONT BACK

The pain is (circle one): 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 (circle all that apply)? 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 (circle all that apply):

Heat/ice Creams/sprays Medications Sling Brace Splint Physical therapy Injection Testing
Surgery (what surgery and where)_____

Have you had any testing (circle all that apply)? X-rays MRI CT EMG
When & where? _____

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

Goals for Appointment (circle all that apply):

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

Name:_____ Appointment Date:_____