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Trauma, Extremity and Reconstruction

New Patient Intake Form

Today's Date: _____

Name: _____ DOB: _____ Age: ____ Phone #: _____

Date of Injury: _____ Was this a work related injury: Y / N Height _____ Weight _____

Side Involved: R / L
(Circle)

Area of Concern: (Circle)
Shoulder
Elbow
Wrist
Hand/Fingers
Hip
Knee
Ankle/Foot
Shoe Size: _____
Other: _____

What is the concern? Pain Stiffness Instability Loss of Motion Other: _____

Describe Complaint: _____

_____

How long has it bothered you? _____

Was there an event that started it? _____

What makes it better/worse? _____

What have you tried to make it feel better?
____ Rest of Activity Modification
____ Medication (list) _____
____ Physical Therapy
____ Injections
____ Other (list) _____
____ Previous Surgery (Date) _____