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Trauma, Extremity and Reconstruction

New Patient Intake Form

Today's Date: _____

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

How were you referred to our office?: _____

Primary Care Physician: _____ Would you like a note sent to PCP? Y/N

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

Side Involved: R / L
(Circle)

Area of Concern: Ankle
(Circle) Foot

Shoe Size: _____

Heel

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) _____