Date:	***St. Clair Orthopaedics*** ***New Patient Form***	Chart #

NAME_____

Age:_____yrs Height:_____ Weight:_____

Optional: (leave blank if decline)

Race:_____Ethnicity:_____

Primary Care Physician _____ Referred by:_____

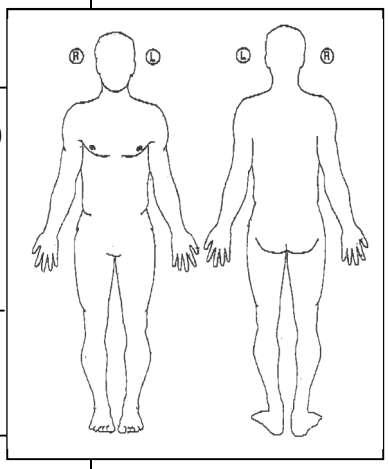
Circle the correct choice….

Problem Area: **Left** **Right** **Both** *ARE YOU: Right or Left Handed*

Neck Shoulder Arm Elbow Forearm Wrist Hand

Finger Back Hip Thigh Knee Leg Ankle Foot Toes

Mark the Location of pain



How long have you had pain/symptoms:_____

What is your pain level: **0 1 2 3 4 5 6 7 8 9 10**

Do you have any Numbness or Tingling: YES NO

If yes, where:_____

Did you have an injury: ___YES NO

If yes, when/where:_____

Is this AUTO or WORKERS COMP: YES NO *Last work date:_____*

Please circle your symptoms:

Mechanical: Clicking ~ Popping ~ Grinding ~ Clunking ~ Giving Away ~ Locking up

Problem is made worse by: Walking Bending Running Stairs Lifting

Timing of Symptoms: During activity At rest During night

How often: Constant Occasional Only with Activity

Recent studies: **Yes** (Where & When) : **X rays** **MRI** **CT** **EMG**

PREVIOUS treatments*: Circle what applies*

Physical Therapy Injections Surgery Chiropractor

**Please flip to back side

Circle *the correct choice….*

Past Medical History: NONE or ***High blood pressure***
Heart disease ***Stroke*** ***Blood Clots*** ***Asthma*** ***Ulcers*** ***Diabetes***
Depression/Bipolar ***Thyroid*** ***Hepatitis*** ***HIV*** ***Alcoholism***
Cancer_____ ***Other:_____***

Past Surgical History: **NONE or List Surgery date, type & right/left:**

_____

_____

Family History: NONE
Or Diabetes Fibromyalgia Arthritis Heart Disease
Father's history: Mother's history: _____

Marital status: Single Married Divorced Widowed #KIDS___

Occupation _____
Sports/Hobbies/Exercises_____

Do you smoke: → *Yes:_____packs/day* *or* *NO*

Height: ___Ft. ___in **Weight: _____Lbs.**

Allergies to medications: NONE or

Please List_____

Medications: **Do not include vitamins/supplements;* *NAMES only*

_____

_____

Review of systems: NONE or Please circle what applies:

Fevers/chills night sweats weight loss/gain chest pain
shortness of breath irregular heart beat wheezing/asthma/cough
heartburn nausea jaundice hay fever hot flashes acne
depression/anxiety bipolar suicidal