SPORTS MED Wheaton Orthopaedics

New Problem Form

Name: _____ DOB: _____ Referred By: _____

Body Part: _____ ☐ RT ☐ LT ☐ Both How long have you had problem? _____

If an injury occurred: Date of Injury_____ Where did injury occur? ☐ Home ☐ Work ☐ Other _____

Describe what happened: _____

Off work due to injury? ☐ NO ☐ YES If yes, last day worked: _____ Work Restrictions: _____

Pain: (Check all that apply or describe) _____

Type: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching Is your pain constant? ☐ NO ☐ YES

Severity: ☐ Mild ☐ Moderate ☐ Severe Does your pain radiate? ☐ NO ☐ YES If so, where? _____

Symptoms: (Check all that apply or describe) _____

☐ Instability	☐ Swelling	☐ Numbness/Tingling	☐ Clicking/Grinding
☐ Weakness	☐ Stiffness/Limited Motion	☐ Catching/Locking	☐ Discoloration

Any prior treatment for this problem? ☐ NO ☐ YES If yes, by whom? _____ When? _____

Tests done (check) ☐ X-ray ☐ MRI Other: _____ When/where was test done? _____

Brace, orthotic or assistive device? ☐ NO ☐ YES If yes, what type? _____

Do you use (check)? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Splint ☐ Cast

Activities that aggravate symptoms:

☐ Up from chair/bed	☐ Running/Jumping	☐ Kneeling/Squatting	☐ Walking
☐ Stairs	☐ Repetitive Motion	☐ Stooping/Bending	☐ Overhead movements
☐ Sitting	☐ Lifting/Carrying	☐ Standing	Other _____

Treatments that alleviate symptoms:

☐ Ice	☐ Heat	☐ Rest	Other _____

Medications you have taken for this problem:

Medication	Does it help?		How long have you been on it?
1. _____	☐ No	☐ Yes	_____
2. _____	☐ No	☐ Yes	_____

_____ _____

Signature of patient or authorized representative or Parent or legal guardian if patient is a minor

Date

_____ _____

Print Name of parent or authorized representative

Relationship to patient