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 ☐ Other _____ 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 ☐ Other_____

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

Tests done (check) ☐ X-ray ☐ MRI ☐ No prior testing ☐ Other: _____ When/where was test done? _____
(List any testing done within last year)

Do you use (check)? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Splint ☐ Cast ☐ Brace ☐ Orthotic Device ☐ None

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 ☐ Exercise ☐ Physical Therapy ☐ Other: _____ ☐ I HAVE NOT TRIED ANY OF THESE

HOW LONG have you tried EACH of these treatments (please be specific)? Did it help? _____

_____

Medications you have taken for this problem:

☐ Ibuprofen/Advil/Motrin ☐ Aleve/Naproxen ☐ Tylenol/Acetaminophen ☐ Tramadol/Ultram ☐ Hydrocodone/Norco/Vicodin
☐ Injection ☐ Other_____ ☐ I HAVE NOT TRIED ANY MEDICATION

HOW LONG did you try EACH of them? HOW MUCH did it help? _____

_____

_____ _____
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