



ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

GENERAL FORM

Name _____ Date _____ Age: _____

I am right-handed _____ Left-handed _____ Truly ambidextrous _____ Height _____

Where is your pain/problem? (Check all involved) Weight _____

- | | | |
|-----------------------------------|--|---------------------------------|
| <input type="checkbox"/> Neck | | <input type="checkbox"/> Back |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Fingers | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Other | | <input type="checkbox"/> Toes |

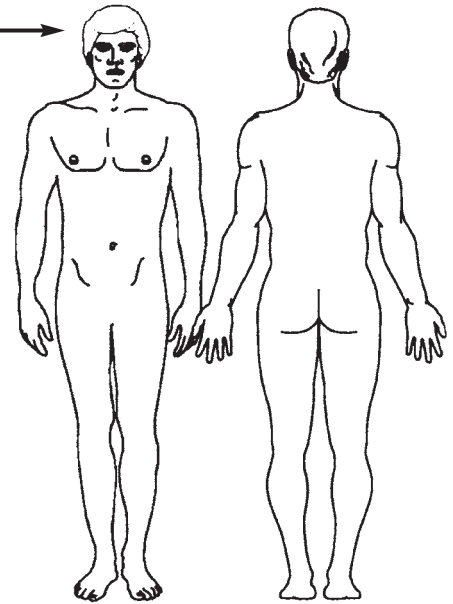
Locate your pain on the following drawing: _____ →

Date of onset of this problem: _____

Nature of onset of this problem: gradually _____ suddenly _____
reinjury of old problem _____

Your major complaint: (check all that apply)

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> aching pain | <input type="checkbox"/> burning | <input type="checkbox"/> stabbing pain |
| <input type="checkbox"/> pain at night | <input type="checkbox"/> deformity | <input type="checkbox"/> loss of motion |
| <input type="checkbox"/> loss of strength | <input type="checkbox"/> swelling | <input type="checkbox"/> going out |
| <input type="checkbox"/> locking | <input type="checkbox"/> grinding | <input type="checkbox"/> numbness or tingling |
| <input type="checkbox"/> other _____ | | |



Is your current problem due to: Accident _____ Injury _____

Where: Home _____ Work _____ Auto _____ Other _____

Describe details: _____

Is the pain mild, moderate or severe? (Check one)

Have you ever had this before?

Has a doctor ever treated you for this condition before and if so how?

Have you taken any medication for this problem, what were they and did they help?

(including prescription drugs, Aspirin, Advil, herbs and supplements) _____

What makes the pain better? _____

What makes the pain worse? _____

Work status: presently working _____ Off work since _____
Off work due to present orthopedic problem _____ Other problem _____

Please rate your level of physical health: Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

Is this a legal or third party liability case?

No _____ Yes _____ Potential _____ Motor Vehicle Accident _____ Work Comp _____ Other _____

Do you have a lawyer and if so who?

*Your email address will be used as your
legal signature if submitted electronically.*

Patient Signature