



# 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"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Elbow    | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Thigh  | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Forearm  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Knee   | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Wrist    | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Leg    | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Hand     | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Ankle  | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Fingers  | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Foot   | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Thumb    |                                |                               | <input type="checkbox"/> Toes   | <input type="checkbox"/> Right | <input type="checkbox"/> Left |

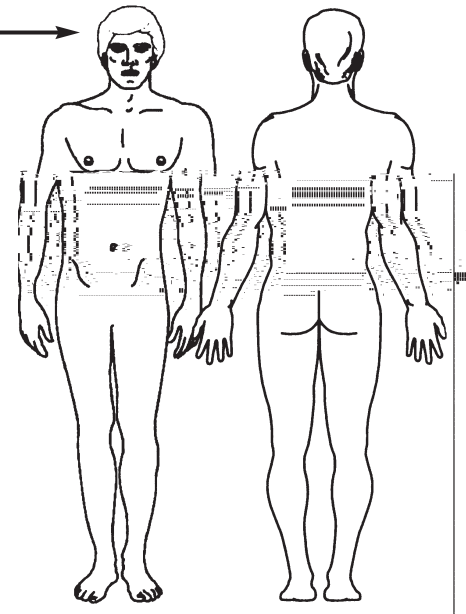
Locate your pain on the following drawing: 

Date of onset of this problem: \_\_\_\_\_

Nature of onset of this problem: gradually \_\_\_\_\_ suddenly \_\_\_\_\_  
reinjury of old problem \_\_\_\_\_

Our 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? (Circle 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 how?

\_\_\_\_\_  
Patient Signature