NEW INJURY
David T Braun MD
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Patient Name *(Please Print)* _____ Date of Birth _____

Height _____ Weight _____

Who requested that you visit this office?

Doctor *(Name)* _____ ☐ Self Referral ☐ Attorney _____

Primary Care Physician _____

What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other *(Chief Complaint)* _____

What body part are you being seen for today? (Location)																					
Neck	☐		Shoulder	☐	Right Left	Elbow	☐	Right Left	Hand	☐	Right Left	Pelvis	☐	Right Left	Knee	☐	Right Left	Foot	☐	Right Left
Back	☐	Mid Lower	Arm	☐	Right Left	Wrist	☐	Right Left	Finger	☐	Right Left	Hip	☐	Right Left	Ankle	☐	Right Left	Toe	☐	Right Left

How long has this problem been present? ☐ Days ☐ Weeks ☐ Months ☐ Other *(Explain)* _____

Please check the box below which best describes your problem.

The pain is ☐ Constant ☐ Comes and goes(intermittent) (Duration)

Severity of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe (Severity)

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____ (Quality)

Are these associated symptoms: ☐ Swelling ☐ Numbness ☐ Weakness (Assoc Symp)

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

Does your pain wake you from sleep? ☐ Yes ☐ No (Timing)

What makes your symptoms **worse**? ☐ Activity ☐ Exercise ☐ Work ☐ Other _____ (Modify)

Which make you feel better: ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____ (Modify)

What medications have you taken or been prescribed for this problem? _____ (Modify)

Check which treatments you have tried — Injection ☐ Yes ☐ No; Brace ☐ Yes ☐ No; Therapy ☐ Yes ☐ No; Cane/Crutch ☐ Yes ☐ No (Modify)

INTERVAL HISTORY: Since your last visit, has your medical history changed? Have you:

Felt any **new** ☐ Numbness ☐ Swelling ☐ Tingling ☐ Weakness ☐ Joint Pain ☐ Catching/Locking

Developed new problems in any of these areas? ☐ Eyes ☐ Heart ☐ Bowels ☐ Skin ☐ Joint ☐ Cancer ☐ Ears ☐ Lungs ☐ Urine ☐ Diabetes ☐ Nerves ☐ Blood Pressure ☐ Blood Diseases

Describe: _____

Ever taken, or are currently taking, blood thinners? ☐ No ☐ Yes Type: _____

Changed your medications? ☐ No ☐ Yes Describe(w/dosage): _____

Acquired any new allergies? ☐ No ☐ Yes Describe: _____

Been hospitalized since your last visit? ☐ No ☐ Yes Describe: _____

Had any surgeries since your last visit? ☐ No ☐ Yes Describe: _____

Had any reactions to Anesthesia? ☐ No ☐ Yes Describe: _____