all american orthopedic
& SPORTS MEDICINE INSTITUTE

Patient Name: _____ **Age:** _____ **Date of Injury:** _____

Medications: _____

Where is your problem? Hip Knee Elbow Shoulder Back Ankle Wrist Other

How long have you had symptoms?
_____ Days _____ Mo _____ Yrs

Which side? (if applicable) Left Right Both

How did you injure yourself? (check all that apply)
- ☐ Automobile Accident
- ☐ Sports (Please describe) _____
- ☐ Work / Job
- ☐ Other (Please describe _____) _____

Please check all that apply:
- ☐ Pain
- ☐ Numbness
- ☐ Instability / Giving Way
- ☐ Dislocation
- ☐ Stiffness
- ☐ Swelling
- ☐ Other _____

Is this a workers comp Claim? Yes / No

Previous treatments to the area _____

How severe is the pain?
0 = none, 10 = severe

At rest 0 1 2 3 4 5 6 7 8 9 10

At work 0 1 2 3 4 5 6 7 8 9 10

Previous surgeries w/ dates _____

Have you had any previous imaging studies?
X-rays MRI CAT Scan

Dates _____ _____ _____

Pain at night? Yes / No

Does it wake you? Yes / No

Are you currently working? Yes / No / Retired

Are you on light duty? Yes/ No

What makes your problem better? _____

What makes your problem worse? _____

Prior diagnosis for this problem? _____

THE INFORMATION NEEDED BELOW IS THE ACTUAL CARD HOLDERS INFORMATION

Name _____ **DOB** _____ **Cell** _____

Relation to Patient _____ **DL #** _____ **Home** _____

Employer _____ **SS #** _____ **Work** _____

Primary Ins _____ **Phone** _____ **Group #** _____ **ID** _____

Secondary Ins _____ **Phone** _____ **Group #** _____ **ID** _____

I have received the Privacy Notice and have been given the opportunity to review its contents

_____ _____
Signature Date