RICHARD P. DUSHUTTLE, M.D. DAVID E. EAKIN, D.O. CYNTHIA S. DEVINE, APRN, CNP
CAPITAL ORTHOPAEDIC SPECIALISTS

Today's Date____/_______/_____

Patient's Name_______________________________ Date of Birth _____/_______/_____
Age: _______ Height: ______feet ________inches Weight: __________lbs
Referring Healthcare provider ________________________
Primary Healthcare provider _________________________
Athletic trainer/school __________________________/____________________________
********Is this a work related injury? □ yes □ no**
Auto related injury? □ yes □ no
Do you have an attorney for this injury? □ yes □ no
Name of attorney__________________________________
****

Chief Complaint

Describe the reason for your visit today? How did the injury occur? Include left/right and body part(s):

____
____
____

Patient Pain/Discomfort Report
(complete for each area of body)

1. Onset of pain/discomfort:
   - □Trauma related – Date of injury _______/_________/______
   - □Auto related – Date of injury ______/_________/_________
   - □Fall related – Date of injury _______/_________/_________
   - □Work related – Date of injury______/_________/__________
   - □ Sudden
   - □ Gradual
2. Pattern of pain/discomfort:
   □ Intermittent □ Persistent □ episodic
3. Course of pain has been:
   □ increasing □ recurrent □ constant □ worsening □ improving/decreasing
4. Severity:
   □ mild □ moderate □ severe □ mild to moderate □ moderate to severe
5. Aggravated by:
   □ physical activity □ changes in direction □ bending □ climbing stairs □ weight bearing
   □ sitting for extended periods □ standing up from sitting position □ standing for extended periods
   □ lifting □ other: ________________
6. Relieved by:
   □ nothing □ medication □ lying down □ rest □ heat □ sitting □ ice
   □ activity □ TENS unit □ other: ________

Does the pain or symptoms radiate to other parts of your body?________________________________

Previous diagnostic tests related to this injury:

□ None
□ Xray □ MRI □ CT □ Arthrogram □ Bone scan □ EMG/PNCVs

Date: ___/______/____Patient Name:______________________________DOB___/_____/___

Previous/current professional evaluations/treatment:

□ None □ Orthopedic surgeon □ Neurologist
□ Rheumatologist □ Primary care physician □ Pain management
□ Emergency room □ Chiropractor □other ___________________

Name of provider:_______________________________________

Previous physical therapy related to this injury?

□ No
□ Yes – where? __________________________

Past Medical History/Past Surgical History

Medical History:

□ No medical problems

□History of MRSA □Diabetes, insulin dependent □Diabetes, non-insulin
□Bleeding disorder □History of blood clot □Thyroid disorder
□HIV/AIDS □Hepatitis □Heart Attack
□Heart disease □Heart Arrhythmia □Pacemaker
□Stroke/Ministroke □High blood pressure □Skin disease/problem
□High cholesterol □Pneumonia □Peripheral vascular disease
□Asthma □COPD/emphysema □Tuberculosis
□Peptic ulcer disease □Kidney stones □Urinary tract infections
□Kidney disease □Renal failure/Dialysis □Arthritis
□Organ transplant □Seizure disorder □Gout
□Fibromyalgia □Osteoarthritis □Migraine headaches
□Cancer □Liver disease □Anxiety
□Drug addiction □Depression □Rheumatoid disease
□Chronic pain □Previously in a chronic pain management program

List any other conditions not mentioned above or explain a checked condition above:

____

Surgical History:

□ No previous surgery □ Previous surgery

____
____

Current Medications (include all including birth control, over the counter medicines, herbal supplements):

□ None

Drug or Medicine	Dose/Amt	Reason for taking
______________________	__________	________________
______________________	__________	________________
______________________	__________	________________
______________________	__________	________________

Currently on blood thinner medication: □ None □ Coumadin (Warfarin) □ Pradaxa (dabigatran)
□ Eliquis (apixaban) □ Aspirin (Ecotrin, Bayer, etc) □ other____________________

□ Currently in chronic pain management (Name of physician or chronic pain management facility):
______________________________ □ Not currently in a pain management program

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Date: ___/______/____Patient Name:_____________________________DOB___/_____/___

Allergies (Include all medications, metals, dyes, bee stings, latex or foods and reaction to each):
□ None

Allergy	Reaction
____________________________	________________________________
____________________________	________________________________
____________________________	________________________________

Family History (Diseases that "run" in your immediate family; M=mother, F=father, S=sister, B=brother)
□ No medical conditions

□ Asthma M F S B	□ Heart disease M F S B
□ Back problems M F S B	□ High blood pressure M F S B
□ Cancer M F S B	□ Diabetes M F S B
□ Orthopedic problems M F S B	□ Stroke M F S B

Social History:
Are you pregnant? □ N/A □ No □ Yes - ______months
Do you smoke? □ No □ Yes
Did you ever smoke? □ No □ Yes
Do you chew tobacco? □ No □ Yes
Do you drink alcohol? □ No □ Yes
Describe substance past/current drug use/abuse (prescription drugs, recreational drugs, anabolic steroids, other performance enhancing substances)?