Lafayette Bone & Joint Clinic Account # _____

Patient Information Sheet

****ENTIRE FORM MUST BE COMPLETELY FILLED OUT****

Date: _____

Patient's Name: _____ **Date of Birth:** ____/____/____

Information below is regarding current symptoms being seen for today:

1. Have you had any treatment for your current condition? (circle one) Did it help?

Physical Therapy: Yes No Injections: Yes No
Chiropractic Care: Yes No Medications: Yes No
Other _____

_____

2. List any tests performed (circle those that apply): MRI X-Ray CT Nerve Test Other _____

Information below is regarding any PRIOR injuries, accidents or conditions:

3. Have you had any treatment of the following **PRIOR** to what you are being seen for today?

a)	Back/Lumbar Problems		Yes	No	g)	Ankle	(Left or Right)	Yes No
b)	Neck Problems		Yes	No	h)	Leg	(Left or Right)	Yes No
c)	Shoulder	(Left or Right)	Yes	No	i)	Wrist	(Left or Right)	Yes No
d)	Knee	(Left or Right)	Yes	No	j)	Foot	(Left or Right)	Yes No

Other: _____

If you answered "Yes" to any of the above:

Describe in detail the condition or injury and list the date(s) of injury or condition: _____

_____

_____

Doctor(s) seen for this _____

Type of Treatment (physical therapy, testing, surgery)_____

Did you miss work? Yes No If Yes, for how long?_____
Did your symptoms resolve? Yes No

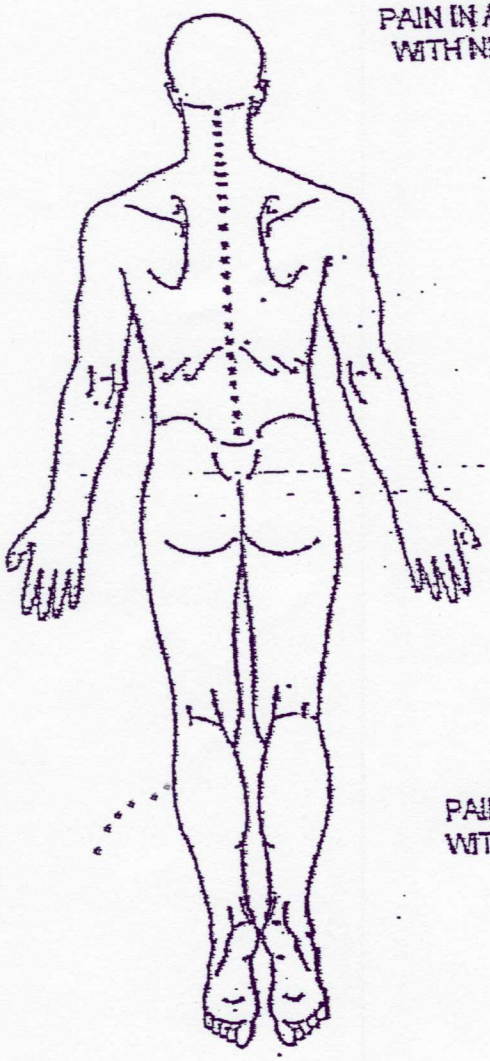
PATIENT PAIN DRAWING

NAME:_____ DATE:_____

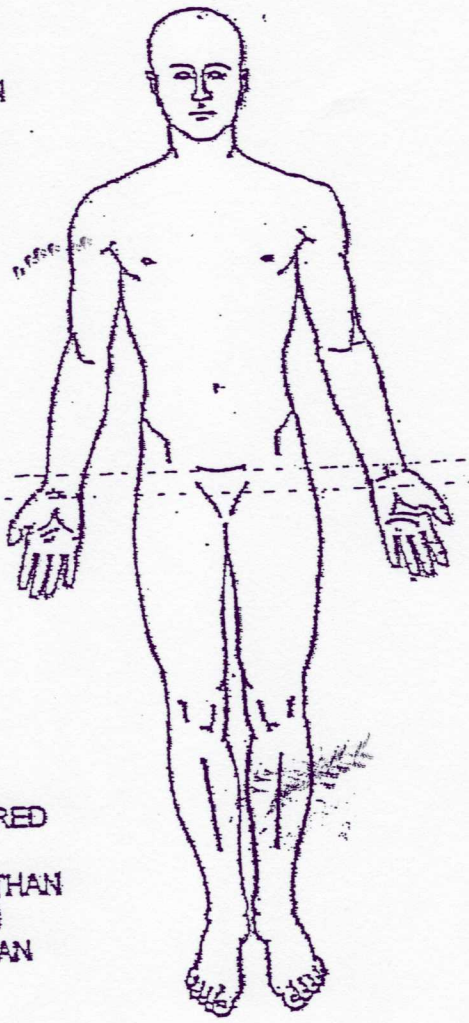
USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS. IT IS NOT NECESSARY TO USE ALL THE SYMBOLS, ONLY THE ONES WHICH MOST AFFECT YOU.

ACHING NUMBNESS PINS & NEEDLES BURNING STABBING OTHER

BACK



FRONT



PAIN IN ARM(S) COMPARED WITH NECK:
WORSE THAN
SAME AS
LESS THAN

PAIN IN LEG(S) COMPARED WITH BACK:
WORSE THAN
SAME AS
LESS THAN

CIRCLE THE QUALITY OF YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10
NORMAL UNBEARABLE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____
PATIENT SIGNATURE