Taos Orthopaedic Institute
Orthopaedic Initial History Survey

Date:______________________________Medical Record #___________________________

Patient Name____ Age_________ ☐ Female ☐ Male

Height ________Weight________ Pulse _______ Saturation__________ SANE Rating_______________________

Consulting Physician? ___________________________________

What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other________________(Chief Complaint)

Did you bring x-rays/MRI? ☐ Yes ☐ No

How long has this problem been present? _______ Days Weeks Months

What body part is involved?						
Neck ☐	**Shoulder** ☐ R ☐ L	**Elbow** ☐ R ☐ L	**Hand** ☐ R ☐ L	**Pelvis** ☐ R ☐ L	**Knee** ☐ R ☐ L	**Foot** ☐ R ☐ L
Back ☐ Mid ☐ Lower	**Arm** ☐ R ☐ L	**Wrist** ☐ R ☐ L	**Finger** ☐ R ☐ L	**Hip** ☐ R ☐ L	**Ankle** ☐ R ☐ L	**Toe** ☐ R ☐ L

Check the box which best fits how your problem started.

Then answer the one question below the box you checked. Use as much space to the right as needed.

NO INJURY (Onset was: ☐ Gradual or ☐ Sudden) **ANSWER:**

Why do you think it started? _____________________________________

INJURY—(NOT AUTO OR WORK) _____________________________________

☐ Date _________. Where and How did it happen? _____________________________________

INJURY AT WORK _____________________________________

☐ Date _________. Where and How did it happen? _____________________________________

WORK RELATED—(BUT NO INJURY) _____________________________________

☐ Date _________. How did your job cause this problem? _____________________________________

AUTO ACCIDENT _____________________________________

☐ Date _________. Where and How was your car hit? _____________________________________

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 there **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)**

Provider Name______________________________**Provider Signature**____