MOTIONORTHOPAEDICS

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Board Certified
Shoulder, Elbow & Knee Surgeon

NAME: _____ **DATE:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____ **HAND DOMINANCE:** RIGHT / LEFT

OCCUPATION: _____

E-MAIL ADDRESS: _____

REFERRAL INFORMATION:

- Who referred you or how did you hear about Dr. Choi?

  _____

- Who is your primary care or family physician?

  _____

What body part is injured?

☐ Shoulder ☐ Knee ☐ Elbow ☐ Other: _____

☐ RIGHT side ☐ LEFT side ☐ Both sides; about equally

Date of Injury/Onset of Symptoms: _____

Please describe how your symptoms began?

☐ Traumatic Injury ☐ Sport Injury ☐ Work Injury ☐ Overuse ☐ Gradually ☐ Spontaneously

_____

_____

_____

_____

_____

Work Related? If you answered yes, please fill out the back page. _____ ☐ Yes ☐ No

What is your pain level on a scale of 0-10 ? At rest: _____. With Activity: _____.

If 100% were normal, as of today what % would you give your body part that is hurting as a grade?

_____%

Have you had this problem before? ☐ Yes ☐ No

What is the type of your pain?

☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Burning ☐ Numbness/Tingling

What is the nature of the pain?

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Does the pain wake you up from sleep? ☐ Yes ☐ No

Do you currently have any of the following?:

☐ Painful popping
☐ Swelling
☐ Grinding
☐ Buckle
☐ Gets stuck
☐ Sensation of catching (something getting caught/pinched between bones)
☐ Locking (unable to straighten the joint because something obstructs it)
☐ Give way (the bones slip out of place)
☐ Slip out of joint
☐ **NORMAL**, I've had none of the above

What makes the pain worse?

_____
_____
_____
_____
_____

What makes the pain better?

_____
_____
_____
_____
_____

What treatments for this injury have you received in the past?

☐ Rest/Activity Modification
☐ Immobilization (splint, sling)
☐ Braces/Orthotics
☐ Chiropractic
☐ Massage Therapy
☐ Anti-Inflammatories
☐ Pain Medications
☐ Steroid/Cortisone Injections
☐ Tylenol
☐ Physical Therapy
☐ X-Rays (Where:_____)
☐ Ultrasound
☐ Electrical Stimulation
☐ MRI/MR Arthrogram
☐ CT Scan

If you had prior testing, what did it show?

_____
_____
_____

What surgeries, if any, have you had for this problem? Please list date and surgeon.

_____
_____
_____

PAST MEDICAL HISTORY (Please check the appropriate boxes):

☐ DIABETES ☐ STROKE ☐ STOMACH ULCERS

☐ OSTEOARTHRITS
☐ RHEUMATOID ARTHRITIS
☐ HEART ATTACK
☐ HIGH BLOOD PRESSURE
☐ DEPRESSION
☐ BLEEDING DISORDER
☐ CURRENTLY PREGNANT
☐ FIBROMYALGIA
☐ LUNG DISEASE
☐ LIVER DISEASE
☐ RECURRENT INFECTIONS
☐ SEIZURES
☐ KIDNEY DISEASE
☐ GOUT
☐ CANCER
☐ ANEMIA
☐ HIV/AIDS

Please explain all yes answers and list any other medical problems?

_____
_____
_____
_____

What Surgeries have you had in the past (Please list date)?

_____
_____
_____
_____

What Medications are you currently taking?

_____
_____
_____
_____

Are you allergic to any medications or environmental allergens? ☐ No ☐ Yes
(If yes, please list all known below)

_____
_____
_____
_____

Do you smoke? ☐ No ☐ Yes (About _____ cigarettes per day)

How much alcohol do you drink? About _____ drinks per day

Do you participate in recreational hobbies or athletic activities? ☐ No ☐ Yes
(If yes, please describe below)

_____
_____
_____
_____

_____ _____
Signature of Patient or Parent of Minor *Date*

WORKERS' COMPENSATION INJURY QUESTIONNAIRE

PLEASE COMPLETE THIS SECTION ONLY IF YOU ARE HERE FOR A WORK-RELATED PROBLEM

WORK HISTORY:

- What is your current occupation? _____
- What company do you current work for? _____
- What was your occupation when you developed the problem that you are being seen for?

  _____
- When did you first start working for this company _____
- If you are no longer working for this company, when did you last work for this company?

  _____
- How many hours a day/a week do you (or did you) work? _____
- Previous Workers' Compensation Injury? ☐ Yes ☐ No
- If yes, please describe? _____

JOB DESCRIPTION (DESCRIBE IN DETAIL):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REPORT ACCIDENT/ACCIDENT OBSERVER:

- Date and time of injury? _____
- What date did you report this injury on? _____
- Who did you report this injury to? _____ Position: _____
- Did anyone else observe accident/injury? ☐ Yes ☐ No
- If YES, Name: _____ Position: _____
- Have you retained an attorney? ☐ Yes ☐ No
- If YES, Name: _____

WORK STATUS HISTORY:

- Have you lost time from work as a result of this new injury? ☐ Yes ☐ No
- If yes, please give dates: _____
- Have you gone back to work? ☐ Yes ☐ No
- If YES, status of work: ☐ MODIFIED ☐ REGULAR
- If modified, list restrictions you have been placed _____

FIRST DOCTOR/HOSPITAL/CLINIC:

- Did you receive medical evaluation a result of this accident? ☐ Yes ☐ No
- If yes, where? _____
- Doctor Name: _____ Date: _____
- Were you examined? ☐ Yes ☐ No
- Were X-Rays taken? ☐ Yes ☐ No
- What diagnosis did the Doctor give you? _____
- Were you given any treatment? ☐ Yes ☐ No
- If yes, what type? _____
- Date of last treatment: _____
- Did the Doctor refer you to another health professional? ☐ Yes ☐ No
- If yes, to whom? _____

PRIOR SIMILAR SYMPTOMS:

- Did you have any physical complaints just before the accident? ☐ Yes ☐ No
- If yes, please describe in detail: _____

  _____
- Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? ☐ Yes ☐ No
- If yes, what part(s)? _____
- Date previously injured? _____ Were you treated? ☐ Yes ☐ No
- If yes, by whom? _____
- Date treatment began: _____ Date treatment ended:_____
- The last date you felt pain or problems from that previous injury? _____

_____ _____

Signature of Patient *Date*