NERVE, BONE & JOINT INSTITUTE

Restore. Regenerate. Reconstruct.
3 Washington Circle NW, #207/208
Washington, DC 20037
T: 202-955-6001 F:202-955-6008

Patient Name: **Age:**

Chief Complaint: Please describe what you are being seen for today:

What is your hand dominance (which hand do you write with)? ☐ Left ☐ Right ☐ Ambidextrous

Injury Type: ☐ Work Comp ☐ Car Accident ☐ Other

Work status:

☐ Currently working ☐ Retired ☐ Unemployed ☐ Disabled prior to injury ☐ Disabled due to injury

Occupation: ----------

Which of the following best describes your work related activities?

☐ Desk work ☐ Occasional lifting ☐ Light lifting ☐ Heavy lifting

At this moment, which of the following best describes your non-work related activities?

☐ Inactive ☐ Occasional sports ☐ Work out 2-3x per week ☐ Work out 4-5x per week

Are you receiving or filing any of the following with regard to your injury? ☐ Yes ☐ No

☐ Worker's compensation ☐ Disability ☐ Lawsuit

Date of injury or when problem began:

Is your problem the result of an injury? Yes ☐ No ☐

What caused your injury?

☐ Fall	☐ Reaching	☐ Collision/contact
☐ Lifting	☐ Fighting	☐ Pulling
☐ Throwing	☐ Twisting	☐ Other (specify):

Check any of the following that happened *at the time* of your injury: Felt

☐ Pain ☐ Heard popping ☐ Had swelling ☐ Dislocation ☐ Fracture ☐ Other (specify):

Check any of the symptoms you are currently experiencing:

☐ Pain ☐ Weakness ☐ Instability ☐ Restricted motion ☐ Other (specify):

If your problem is the result of an injury, where did it occur? (Check one answer only) ☐ N/A

☐ Home ☐ Work ☐ Motor vehicle accident ☐ Exercise ☐ Sport competition ☐ Other (specify):

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Have you received previous treatment for your current problem? If yes, please specify: ☐ Yes ☐ No

☐ Surgery	Describe:
☐ Injection	☐ Corticosteroid ☐ Hyaluronic acid ☐ Other (please describe):
☐ Physical therapy	PT duration:
☐ Prescription meds	Type and duration splinting:
☐ NSAIDs	Hand therapy duration:

Check the words that best describes the character of your pain today.	**What makes the pain better?**	**What makes your pain worse?**
☐ Aching ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Gnawing ☐ Penetrating ☐ Numb ☐ Sharp ☐ Tender ☐ Burning ☐ Exhausting ☐ Nagging ☐ Unbearable ☐ Other (specify):	☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Sitting ☐ Lying down ☐ Walking ☐ Standing ☐ Nothing in particular ☐ Other (specify):	☐ Sitting ☐ Standing ☐ Lying down ☐ Walking ☐ Exercising ☐ Activity in general ☐ Stopping/ bending ☐ Other (specify): ☐ Nothing in particular

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Allergies: Please list any allergies that you currently aware of

1.	2.
3.	4.

Medications: Please list any medications you are currently taking, both prescription and over the counter

1.	2.
3.	4.
5.	6.
7.	8.

Medical History: Please check all that apply

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Congestive heart failure
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Enlarged prostate
- ☐ GERD
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pacemaker/ AICD
- ☐ Peptic ulcer disease
- ☐ PVD
- ☐ Prostate cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Other:

Surgical History: Please check all that apply and specify the date for each. For previous arthroscopy, please indicate the type of surgery (e.g. meniscus repair, rotator cuff repair, etc). For joint replacement, please indicate which joint(s)

- ☐ Appendectomy: --------
- ☐ Arthroscopy: ----------
  Type: ----------
- ☐ Breast surgery: --------
- ☐ CABG: --------
- ☐ Cholecystectomy: --------
- ☐ Colon surgery: --------
- ☐ C-Section: --------
- ☐ Hernia repair: --------
- ☐ Hysterectomy: --------
- ☐ Joint replacement:
  Joint:
- ☐ Spine surgery: --------
- ☐ Tubal ligation: --------
- ☐ Other: : --------

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Family History: Please check whether a family member has had any of the following conditions

* **Note:** Maternal refers to your mother's side of the family; paternal refers to your father's side of the family

Relationship	Deceased (Yes/No)	Alzheimer's	Arthritis	Asthma	Cancer	Diabetes	Heart Disease	High Cholestero	Hypertension	Kidney Diseases	Mental Illness	Stroke	Substance Abuse	Thyroid Disease
Mother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

Alcohol Use: ☐ Yes ☐ No

Drinks per week: please enter the number of drinks associated with each type of alcohol

Coffee Use: ☐ Yes ☐ No

Coffee consumption per week:

Drug Use: ☐ Yes ☐ No

If yes, please describe type:
(for example: marijuana, methamphetamines, steroids etc.)

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Tobacco Use (this refers to both present & past tobacco use): ☐ Yes ☐ No

If yes, describe type:

Frequency:

Quit date (if applicable):

Smokeless tobacco (this refers to both present and past smokeless tobacco use): ☐ Yes ☐ No

If yes, please describe type:

Frequency:

Quit Date (if applicable):

Review of Systems: In order to get a better understanding of your overall health, please check any of the following that you are *currently* experiencing

General	**Eyes**	**Gastrointestinal**	**Endo/Heme/Allergies**
☐ Fever	☐ Blurred vision	☐ Heartburn	☐ Easily bruise/bleed
☐ Chills	☐ Double vision	☐ Nausea	☐ Environmental allergies
☐ Weight loss	☐ Eye pain	☐ Vomiting	**Neurological**
☐ Fatigue	**Cardiovascular**	☐ Abdominal pain	☐ Dizziness
☐ Weakness	☐ Chest pain	☐ Diarrhea	☐ Tingling
Skin	☐ Palpitation	☐ Constipation	☐ Tremor
☐ Rash	☐ Shortness of breath	**Genitourinary**	☐ Seizures
☐ Itching	☐ Leg swelling	☐ Painful urination	☐ Loss of consciousness
Head, Eyes, Ears, Nose and Throat	**Respiratory**	☐ Urgency	**Psychiatric**
☐ Headaches	☐ Cough	☐ Frequency	☐ Depression
☐ Hearing loss	☐ Coughing up blood	**Musculoskeletal**	☐ Substance abuse
☐ Ear pain	☐ Mucus production	☐ Neck pain	☐ Nervous/anxious
☐ Congestion	☐ Shortness of breath	☐ Back pain	☐ Insomnia
☐ Sore throat	☐ Wheezing	☐ Joint pain	☐ Memory loss