

Name: _____ Date: _____

Orthopedic History: Trauma Gradual Recurrent MVA Liability Work Related (Comp)

Date of Injury: ____/____/____ Description of injury: _____

Side: Right Left Dominant: Right Handed Left Handed

History of Present Injury or Complaint:

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

X-rays MRI CT Scan EMG Bone Scan Bone Density Bloodwork None

Tests performed at: _____

PRIOR TREATMENT of present injury or complaint: Yes No (if "Yes" see below)

Anti-Inflammatories: _____

Injections (dates & number): _____

Chiropractic: _____

Surgery: _____

YOUR MEDICAL DOCTOR: Name: _____

Address: _____

Phone: _____

YOUR REFERRING DOCTOR: Name: _____

Address: _____

Phone: _____

PATIENT SIGNATURE: _____

MD SIGNATURE/DATE: _____