

SNAKE RIVER ORTHOPEDICS

DATE: _____

Name: _____ Age: _____ Phone: (____) _____

Dominant Hand: (Circle one) Right Left Date of Birth: _____

What is the nature of your problem/injury? _____

How did this happen? _____

When did this happen? (Date or time frame) _____

Has this happened before? _____

Type of pain: (Circle those that apply)

Local	Numbness/Tingling	Radiating to _____
Burning	Aching	Dull
Clicking	Popping/Snapping	Constant/Intermittent
Stabbing	Pulling	Other: _____
Joint/Muscle	Sharp	_____

Do you have pain at night? _____ Severity: Scale of 1-10 (10 is worst) _____

Do you have pain at rest? _____ Severity: _____

Activities/Movements that make it worse: _____

Has anything made it better for you? _____

What treatment(s) have you tried so far?

Medications? _____

Splints? _____

Physical Therapy? _____

Have you seen a physician? _____

Who referred you to Dr. Williams? _____

Do you have any allergies to medications? _____

Please list all medications taken daily: _____

Known Medical Problems: "S" for Self, "F" for Family

____ Arthritis	____ Joint Swelling	____ High Blood Pressure
____ Gout	____ Dislocated Joint	____ Heart Problems
____ Osteoporosis	____ Torn Cartilage	____ Respiratory Problems
____ Cancer	____ Torn Ligaments	____ Kidney Problems
____ Anemia	____ Bleeding Problems	____ Intestinal Problems
____ Diabetes	____ Alcoholism	____ Skin Disease

Do You Smoke? _____ Packs Per Day? _____ How long? _____

Do You Drink? _____ Drinks Per Day? _____

Height: _____ Weight: _____

Additional Comments or Concerns about Your Health: _____

