

Orthopaedic Surgery & Sports Medicine

New Patient Intake- Shoulder, Elbow/Upper Extremity

Patient Name:				
DOB:	Age:	Referred by: _		
Reason for Today's	Visit:			
Right shoulder Lef	it Shoulder □ Righ	t Elbow 🗌 Left Elbow	Other (Wrist, Forearm, etc.):	
Check one of the fo	llowing:			
No Injury- estimated	date symptoms be	egan:		
☐ Injury- date of injury If injury: Do you have neck pain? Numbness/tingling in arr Did you experience imme Is this a sports related in	□ YES □ NO ms? □ YES □ NO ediate swelling? □	YES 🗖 NO		
What is your dominant	t hand? 🗌 LEFT 【	RIGHT		
Do you have pain at nig Check all symptoms the Numbness	nat apply. Tingling Throbbing Popping Shooting Pains	Stiffness Instability Aching Stabbing Pains	Constant	
What makes it worse? What makes it better?				
Previous Treatme	ent:			
Have you had any rece If yes, (circle one) <u>Type of Imaging</u> : X Ray Date Performed:	MRI CT		l spine) 🗌 YES 🗌 NO	
Have you had any prev If yes, Procedure:			nity?	
		-	O (FOR SHOULDER PATIENTS ONLY) : Provider:	

What treatmen	ts have you tried, if	any? (Check all that apply)	
Cortisone Injection	s Physical Therapy	y Warm Compresses	
Icing Voltare	en Gel	Other	
Aleve TylenolI	AdvilAspirin buprofen	er medications? (Check all that) s?	at apply)
, ,	IV Sedation	, ,,	esia? (Check all that apply or fill in the blank)

Medical/Social History:

Do you have any blood relatives with osteoporosis or arthritis? 🗌 YES 🗌 NO

Do you smoke? 🗌 YES 🗌 NO If yes, how many packs a day_____ If yes, how much in a week _____

Do you drink? 🗌 YES 🗌 NO

Allergies: Please list any additional allergies below.

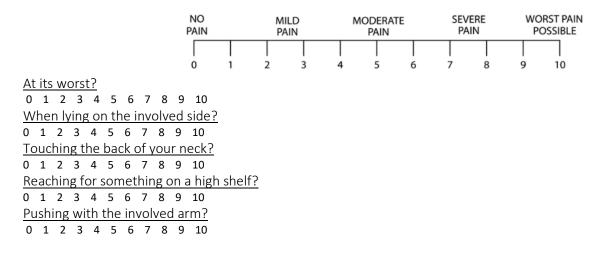
Medication	Date Noted/Reaction

Medications: Please list any medications you are currently taking including over-the-counter medication.

Medication Name	Dosage

Pain Scale: FOR SHOULDER PATIENTS ONLY

Please describe which point on the scale from 0= no pain to 10= the worst pain imaginable, best describes the pain you are experiencing in each of the following situations:



Disability Scale:

Please describe the degree of difficulty, on a scale from 0= no difficulty to 10= so difficult it requires help while performing the following activities:

Washing your hair? 0 1 2 3 4 5 6 7 8 9 10 Washing your back? 0 1 2 3 4 5 6 7 8 9 10 Putting on a shirt? 0 1 2 3 4 5 6 7 8 9 10 Putting on a shirt that buttons down the front? 0 1 2 4 5 6 7 8 9 10 3 Putting on your pants? 0 1 2 3 4 5 6 7 8 9 10 Placing an object on a high shelf? 0 1 2 3 4 5 6 7 8 9 10 Carrying a heavy object of 10lbs? 0 1 2 3 4 5 6 7 8 9 10 Removing something from your back pockets? 0 1 2 3 4 5 6 7 8 9 10