LAKE ORTHOPAEDIC ASSOCIATES, INC.

❒ NEW PATIENT ❒ NEW PROBLEM ❒ WORKER'S COMPENSATION

NAME _____ BIRTH DATE _____ AGE _____

Were you referred to our office? Yes _____ No _____

**If yes, please provide the doctor's first and last name and phone number

_____

What part of the body are you seeing the doctor for today?_____ ❒ Right ❒ Left

What is your level of pain today: 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain; 10 = terrible pain)

Was this condition related to:

A. Employment? Yes ____ No ____

B. Auto Accident? Yes ____ No ____

C. Other Accident? Yes _____ No_____

Please describe the accident or injury in detail. _____

_____

* If **no** accident or injury, describe complaint/symptoms. _____

_____

What treatments have you had for this problem: _____

Indicate the exact date of the injury **or** the date your symptoms appeared _____/_____/_____

Are you currently working? Yes _____ No _____if no, last day worked _____

Where did the accident take place? (home, work, etc...) _____

_____

Has another doctor, emergency room, hospital or urgent care facility treated you for this problem?

Yes_____ No_____

If yes, Please give the first and last name of the doctor, or the complete name of the hospital.

_____

Were X-rays taken? Yes_____ No_____ **If Yes, Where?_____

Any other testing? (i.e. EMG, MRI) Yes_____ No_____ **If Yes, Where?_____

_____

X _____ _____

Patient/Guarantor Signature **Date**

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