LAKE ORTHOPAEDIC ASSOCIATES, INC.

Mentor: (440) 352-1711
Willoughby: (440) 942-1050

Please complete this form and hand carry it to your appointment.

REASON FOR YOUR VISIT

☐ 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 = 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 provide the doctor's first and last name 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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