UNIVERSITY ORTHOPAEDIC CLINIC

ORTHOPAEDIC · SPINE · SPORTS MEDICINE

Date: _____ Medical Record # _____

Patient's Name: _____

Patient's Email: _____

Medical History:

Have you had **ANY** Physical/Occupational Therapy this year? ☐ Yes ☐ No

If so, where and how long did you receive treatment? _____

_____

Have you recently had **ANY** Home Health Services? ☐ Yes ☐ No

If so, who provided the service and when? _____

Have you ever had any of the following: (Circle)

Cancer
Pacemaker
Metal Implants
Gout
Osteoporosis
Fibromyalgia

Are you pregnant, or is there any possibility that you could be? _____

Is this a work related injury? ☐ Yes ☐ No

What type of work do you do? _____

What is physically the hardest part of your job with your current pain? _____

_____

_____

How many times have you fallen in the past 12 months? _____

If you have fallen in the past 12 months, were you injured? _____

_____

_____