Chart ________________

Klamath Orthopedic and Sports Medicine Clinic
New Condition Form

Name: ____

Date of birth: ____________________ Appointment date: ___________________

Please complete as it pertains to today's visit

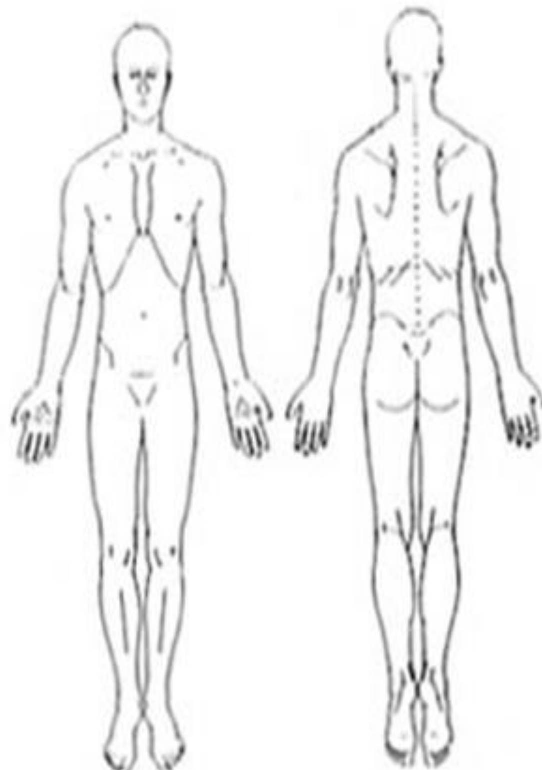
Pain location? __________	Current pain? 0 - 10 _____	Onset? ☐ Gradual ☐ Sudden	How long have you had this pain?	Does your pain radiate? Where?_____________

Pain pattern?	Description of pain?	Associated Symptoms?
☐ New ☐ Chronic ☐ Constant ☐ Intermittent	☐ Aching ☐ Burning ☐ Dull ☐ Pressure ☐ Radiating ☐ Sharp ☐ Cramping ☐ Tightness ☐ Heavy ☐ Other:__________	☐ Numbness/tingling ☐ Nausea ☐ Palpitations ☐ Shortness of Breath ☐ Sweating ☐ Vomiting ☐ Other _____________________
What increases your pain?	**What have you tried to relieve your pain?**	**What decreases your pain?**
☐ None ☐ Breathing ☐ Movement ☐ Touching ☐ Other:_____________	☐ Cold ☐ Heat ☐ Medications ☐ Repositioning ☐ Rest ☐ Other	☐ Nothing ☐ Massage ☐ Assistive Devices (ie: cane, walker) ☐ Cold Therapy ☐ Medication ☐ Deep Breathing ☐ Moist Heat ☐ Exercise ☐ Repositioning ☐ Immobilization ☐ Other

Please **circle** on the diagram the location of your pain.

Please mark with an **X** the location of any metal you may have in your body.

Please mark with **+** signs any areas of numbness you may have.



Reason for being seen today: ____

When did this problem begin? ____

Is your condition the result of an accident/injury? ____

If due to an accident/injury, what is the date of injury? Briefly describe the incident:

____

____

____

____

In the past six months have you had any of the following for the body part you are being treated for today? (Include date and location where the testing/study was performed).

- CT scan ____
- MRI ____
- X-ray ____
- EMG or nerve conduction studies ______________________________
- Injections ____
- Physical Therapy ____

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