

GEORGIA BONE AND JOINT

orthopaedic specialists

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Patient Name: _____ Date: _____

Referring Doctor: _____ Chief Complaint: _____

Date of injury/onset of pain: _____ If injury, explain in detail how it occurred: _____

Have you had any of the following? *Check all that apply.*

MRI Bone Scan CT Scan X-rays

If so, where and when: _____

Check all the conditions that apply to you:

Fever Chills Dizziness Headaches Nausea

Vomiting Weight Loss Infection Loss of bladder or bowel control

Numbness/Tingling: Legs: right left Arms: right left

Pain in limbs: Legs: right left Arms: right left

What makes pain better? _____

What makes pain worse? _____

Pain Scale (0-10): *Circle one.* 0 1 2 3 4 5 6 7 8 9 10

Treatment History: *Please check one.*

Physical Therapy: yes no

Helpful: yes no

Bracing: yes no

ESI: yes no

Medicines: yes no

Chiropractor: yes no

Scoliosis Patient or Family Member: yes no

Other: _____

For Office Use Only

Date: _____ - _____ - 2005

Chart Number: _____