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Orthopedic Associates of Long Island

Chief complaint form

NAME: _____ **DOB:** _____

OCCUPATION: _____

Is the injury work related? ☐ Yes ☐ No Date: _____

Is injury a result of a car accident? ☐ Yes ☐ No Date: _____

Current work status: ☐ Full time ☐ Part time ☐ Homemaker ☐ Retired ☐ Disabled ☐ Not Employed

PLEASE LIST SPORTS OR ACTIVITIES: _____

CHIEF COMPLAINT:☐ Foot ☐ Ankle ☐ Knee ☐ Shoulder ☐Elbow ☐Hip ☐low back ☐ Neck

SIDE: ☐ Right ☐ Left ☐ Both

WHICH BEGAN ON: ___/___ /____ (approximate date or state duration)_____months/years

WHAT TYPE OF INJURY? ☐ No Specific Injury ☐ Non-Contact/Twisting Injury ☐ Contact injury

CURRENT LEVEL OF DISCOMFORT: ☐ Mild ☐ Moderate ☐ Severe

THE DISCOMFORT IS: ☐ Constant ☐ Intermittent ☐ Only With Activity ☐ Sharp ☐ Dull

AND: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (Check Any That Apply): ☐ Instability/Giving Way/Buckling ☐ Dislocation ☐ Clicking/Popping ☐ Locking/Catching ☐Grinding
☐ Stiffness ☐ Pain at Rest ☐ Night Pain ☐ Electric/Shooting Pains ☐ Swelling
☐Numbness/Tingling

HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM IN THE PAST: ☐ Yes ☐ No

IF YES, WHAT TREATMENTS HAVE YOU TRIED?

☐ None ☐ Ice ☐ Heat ☐ Activity Modification ☐ Injections ☐ Orthotics
☐ Cast ☐ Rest ☐ ER Visit ☐ Physical Therapy ☐ MRI ☐ Cat_Scan ☐ Bone Scan
☐ EMG/Nerve Study

☐ Bracing (type)_____☐ Medications (name)_____