Piedmont Orthopedics | ORTHOATLANTA

NEW PATIENT REGISTRATION FORM

Date of Visit: _____ Account #_____

Patient Full Name: _____ Age: _____ DOB: _____

Who referred you to our office? _____ Height: _____ Weight: _____

Reason for Visit

Please describe the reason for today's visit: _____

When did your current symptoms begin or injury occur? _____

Are your current symptoms related to an injury? ☐ No ☐ Yes Please describe: _____

_____

If your current symptoms are related to an injury do you have a lawyer? ☐ No ☐ Yes

Have you had this problem before? ☐ No ☐ Yes Please describe: _____

_____

How would you describe your pain now (Please mark all that may apply)?

☐ Constant ☐ Burning ☐ Dull

☐ Intermittent ☐ Sharp ☐ Throbbing

☐ Stinging ☐ Aching

Pain is:

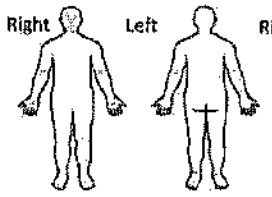
☐ Equal on both sides

☐ Only or worse on the right side

☐ Only or worse on the left side

Mark areas below where you are having pain with an X, and numbness/tingling with an O.

FRONT BACK



Please rate your pain now.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Ever

Please rate your pain at its worst.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Ever

What makes your pain worse?

☐All Activity ☐Lifting ☐Coughing

☐Sitting ☐Bending ☐Sneezing

☐Standing ☐Twisting ☐Lying Down

☐Walking ☐Nothing

☐The pain wakes you from sleep

☐Other _____

What makes your pain better (Please mark all that may apply)?

☐Nothing ☐Activity ☐Walking

☐Lying Down ☐Exercise ☐Twisting

☐Ice ☐Sitting ☐Bending forward

☐Heat ☐Standing ☐Bending backward

☐Other _____

Have you had:

☐ Inability to urinate ☐Loss of balance while walking

☐ Arm or leg weakness ☐Falls

Are your symptoms getting:

☐ Better ☐ Worse ☐ Staying the Same

What is your current work status?

☐ Out of Work ☐ Light Duties ☐Full Duties ☐Retired

List anything else you can not do or have had to change because of your symptoms. _____

_____

Who else have you seen for this problem?

_____

What tests have you had for this problem?

☐ X-rays ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Blood Work

☐ EMG or Nerve Conduction

Have you tried any of the following?

☐ Chiropractor ☐Physical Therapy

☐ Accupuncture ☐Massage Therapy

Have you received any injections?

☐No ☐ Yes What kind? _____

For Office Use Only: Blood Pressure ___/___ Pulse _____ Temperature _____ revised 01/2015 cmc