Rainier Orthopedic Institute
Wendy Heusch, DO

NEW PATIENT EVALUATION

NAME: ____ **DOB**___________**AGE**_____

Dominant hand: ☐ R ☐ L Height:________ Weight:__________ ☐ F ☐ M

Who requested that you visit this office? ☐ Doctor (name) :_____________ ☐ Self ☐ Attorney

1. Chief Complaint-Main reason for visit: ☐ Pain ☐ Numbness ☐ Weakness ☐ Other:________________
2. Location- What body part is involved? (check the **MAIN** reason for your visit)

☐ **Neck** ☐ **Back**	**Shoulder** ☐ **R** ☐ **L**	**Elbow** ☐ **R** ☐ **L**	**Hand** ☐ **R** ☐ **L**	**Pelvis** ☐ **R** ☐ **L**	**Knee** ☐ **R** ☐ **L**	**Foot** ☐ **R** ☐ **L**
Leg ☐ **R** ☐ **L**	**Arm** ☐ **R** ☐ **L**	**Wrist** ☐ **R** ☐ **L**	**Finger** ☐ **R** ☐ **L**	**Hip** ☐ **R** ☐ **L**	**Ankle** ☐ **R** ☐ **L**	**Toe** ☐ **R** ☐ **L**

3. Have you had any prior problems with this joint? ☐ Yes ☐ No
4. Duration: How long has this problem been present? ____ Days ____ Weeks____ Months ____ Years
5. Check the **ONE** box below that best describes how your problem **started.** Then use the space to the right to answer the **ONE** question below the box you checked.

☐ **No injury** (onset was ☐ Gradual or ☐ Sudden)

☐ **Injury** (from accident or Sport NOT work or Auto)

☐ **Injury at work Date:**___________

From a ☐ Lift ☐ Twist ☐ Bend ☐ Pull ☐ Reach

☐ **Work Related** (But **NO** Injury)

Date:_________How did your job cause this problem?

☐ **Auto Accident Date:**____________

Answer Comments:
____
____
____
____
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Please check the box(es) in each category that best describes your problem:

6. **Severity of pain**: ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely severe
7. **Quality of pain**: ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning ☐Other_____________
8. **Timing of pain**:☐Constant ☐Comes and Goes(intermittent)Does pain wake you from sleep?☐Yes ☐No
9. **Do you have** ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling
10. **Since my problem started it is**: ☐Getting better ☐Getting worse ☐Unchanged
11. **What makes your problem worse?** ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐Stairs ☐ Sitting ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling
12. **What makes it better?** ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other________________
13. **What medications have you taken for this?**____
14. **Which treatments have you tried?** ☐Injection ☐Brace ☐Therapy ☐Cane/crutch
15. **What tests have you had?** ☐X-rays ☐MRI ☐CAT scan ☐Bone scan ☐Nerve test (EMG)

Patient Signature_________________________________ Date:________________