Michigan Orthopedic Center

Tell Me About Your Injury: (Please fill out the front of this form)

Name: ______________________ DOB: _______________ Today's Date: _____________

Date injury occurred: ___________ Family/Primary Care Doctor: ______________________

What did you injure: ____

Where were you when the injury occurred: ____

How did this injury happen: ____

Have you seen any other doctors regarding this injury? ______ Please explain: _______________
____

What has been done for this injury to make it feel better? (Circle all that apply)

Ice Elevation Splint/Cast Cane/Crutches/Walker Sling/Immobilizer

Medication (Please list): ____

Rate your discomfort now: (Circle) None=1 2 3 4 5 6 7 8 9 10=Severe

Rate your discomfort at the time of injury: (Circle) None=1 2 3 4 5 6 7 8 9 10=Severe

Do you have any numbness and tingling? Yes/ No If Yes, please explain: ___________________

Is this work related? Yes/ No Are you currently working? Yes/ No

Is this auto related? Yes/ No

Have you ever been injured in this area before? Yes/ No If Yes, please explain: _____________
____

Completed by: ______________________ Relationship: ____________________

Reviewed by: _______________________