

ORTHOPAEDIC INITIAL ASSESSMENT FORM

Current Hx:

Previous Hx:

General Health: ☐ Refer to medical questionnaire

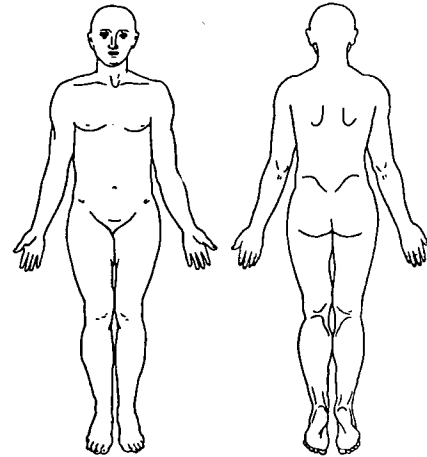
Medications: ☐ Refer to medical questionnaire

Date: _____

Patient: _____ DOB: _____

Referring MD: _____ FMD: _____

☐ Verbal consent obtained to proceed with the assessment



☐ Worse
☐ Same
☐ Better

☐ Pain
☐ N
☐ P&N

Social Hx:

Occupation: _____

☐ Working ☐ Modified ☐ Off ☐ Retired

Diagnostics:

Onset:	Insidious / Sudden	
Intensity:	Current: ____ / 10	Past wk: ____ / 10
Duration:	Constant / Intermittent	
Irritability:	low / mod / high	
Character:		
Pattern:	AM status: _____ DAY end: _____	
Disturbed sleep:	yes / no	
Sleeping position:	supine / prone / side (R / L)	

SCREENING QUESTIONS:

- | | |
|--|---------------------------------------|
| ☐ Valsalva | ☐ Dizziness |
| ☐ Bil/Quad Paraesthesia | ☐ Diplopia |
| ☐ Saddle Paraesthesia | ☐ Dysphagia |
| ☐ Bowel & Bladder | ☐ Dysarthria |
| ☐ Facial/lip Paraesthesia | ☐ Drop attacks |

- | |
|--|
| ☐ Night Pain |
| ☐ Unexplained Weight Δ |
| ☐ Fever |
| ☐ Pregnancy |

- | |
|------------------------------------|
| ☐ Headaches |
| ☐ Nausea |
| ☐ Tinnitus |
| ☐ Meds: |

Aggravates:

Eases: