NEW PATIENT
David T Braun MD
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Patient Name *(Please Print)* ______________________ Date of Birth ______________

Height ________ Weight ________

Who requested that you visit this office?
Doctor *(Name)* ______________ ☐ Self Referral ☐ Attorney ______________

Primary Care Physician ______________________________

What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other *(Chief Complaint)* ________

What body part is involved?													**(Location)**
Neck	☐	Shoulder	☐ Right ☐ Left	Elbow	☐ Right ☐ Left	Hand	☐ Right ☐ Left	Pelvis	☐ Right ☐ Left	Knee	☐ Right ☐ Left	Foot	☐ Right ☐ Left
Back	☐ Mid ☐ Lower	Arm	☐ Right ☐ Left	Wrist	☐ Right ☐ Left	Finger	☐ Right ☐ Left	Hip	☐ Right ☐ Left	Ankle	☐ Right ☐ Left	Toe	☐ Right ☐ Left

How long has this problem been present? ☐ Days ☐ Weeks ☐ Months ☐ Other *(Explain)* ________

Check the box which best fits how your problem started. Then answer the one question below the box you checked.
Use as much space to the right as needed.

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden ________
Why do you think it started? ________

INJURY - (<u>Not</u> Auto or work)
Date ________ Where or how did it happen? ________

INJURY AT WORK
Date ________ Where or how did it happen? ________

INJURY RELATED-(BUT NO INJURY)
Date ________ Where or how did it happen? ________

AUTO ACCIDENT-Date/Details-
Date ________ Driver/Passenger taken to ER? ________

Please check the box below which best describes your problem.

The pain is ☐ Constant ☐ Comes and goes(intermittent) (Duration)

<u>Severity</u> of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe (Severity)

What is the **<u>quality</u>** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other ________ (Quality)

Are these associated symptoms: ☐ Swelling ☐ Numbness ☐ Weakness ☐ Catching/Locking (Assoc Symp)

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

Does your pain wake you from sleep? ☐ Yes ☐ No (Timing)

What makes your symptoms **<u>worse</u>**? ☐ Activity ☐ Exercise ☐ Work ☐ Other ________ (Modify)

Which make you feel better: ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other ________ (Modify)

What medications have you taken or been prescribed for this problem? ________ (Modify)

Check which treatments you have tried Injection ☐ Yes ☐ No Brace ☐ Yes ☐ No Therapy ☐ Yes ☐ No Cane/Crutch ☐ Yes ☐ No (Modify)