CurPoint™ ORTHOPEDIC

Adult New Patient Registration Orthopedics

Patient Information (please print)

Person completing this form | Relationship (if not patient)

Referring provider | Phone number | Email

Would you like a copy of today's report sent to this doctor? ❑ Yes ❑ No

Primary Care Provider | Phone number | Email

Would you like a copy of today's report sent to this doctor? ❑ Yes ❑ No

Today's Visit

Reason for today's visit

Which side hurts? ❑ Left ❑ Right ❑ Both | How long has your reason for today's visit been going on?

How did it start?

Dominant hand ❑ Left ❑ Right ❑ Both | Pain description ❑ Dull ❑ Sharp ❑ Tingling ❑ Other:

Pain occurs when? ❑ At rest ❑ With activity ❑ At night ❑ Other:

Rate your pain:

No pain	1	2	3	4	5	6	7	8	9	10	Most extreme
	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	

What reduces pain? ❑ Medicine ❑ Ice ❑ Heat ❑ Rest ❑ Elevation

Your problem has: ❑ Improved ❑ Worsened

Any other symptoms associated with the current problem?

Does your home have: (check all that apply) ❑ 1 story ❑ 2 stories ❑ 3+ stories ❑ Entrance steps ❑ Elevator

Do you take public transportation? ❑ Yes ❑ No

Do you exercise regularly: ❑ Yes ❑ No Are you involved in organized sports? ❑ Yes ❑ No

Required Information

Did this injury happen while working? ❑ Yes ❑ No Does this injury relate to an auto accident? ❑ Yes ❑ No

Is this injury related to a pending lawsuit? ❑ Yes ❑ No

Patient or Legal Guardian Name (Print)

Patient or Legal Guardian Name (Signature) | Date