ORTHOPEDIC INSTITUTE of SANTA BARBARA

New Problem/Injury

Welcome back to Dr. Gallivan's office. Thank you for taking the time to fill out this form- it helps us provide you with the best orthopedic care

Name: _____ **Date:** _____

Allergies (medications and/or metals): _____ NKDA / PCN / Sulfa / Latex

Primary Care Physician: _____ **Height:**_____ **Weight:**_____

History of injury: Which body part is to be examined: R / L _____

How did you get injured (detailed as possible): Injury / No specific injury _____

_____

_____

Date of Injury / Onset: _____ **Is this injury related to Worker's Compensation?** Y / N

How long have you had the condition? _____

Please rate and describe your pain:

0 None	1	2	3	4	5	6	7	8	9	10 Severe

Use the above scale to define the following: Pain at rest: _____ **Pain with Activity:** _____ **Night Pain:** _____

Is the pain (check if applicable): ☐ Constant ☐ Occasional ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing
☐ Throbbing ☐ Worse at night ☐ Activity inhibiting ☐ Other:_____

If any, what mechanical symptoms are you experiencing: ☐ Locking ☐ Catching ☐ Giving way ☐ Popping
☐ Grinding ☐ Other:_____

The pain is worse with (ex- stairs): _____ **and better with:**_____

Have you ever seen a physician for this injury before: No / Yes **:** _____

What previous treatment(s) have you tried? ☐ Nothing ☐ Physical Therapy ☐ Bracing ☐ Chiropractic
☐ Injections (If so, when and what type?)_____
☐ Surgery/Other (describe):_____

Do you have any recent: ☐ **Xrays Date:**_____ **Location: Pueblo / Cottage** _____
☐ **MRI Date:**_____ **Location: Pueblo / Cottage** _____

Medications Currently taking:_____

_____

Any new medical problems?_____

_____