GOTHAM CITY ORTHOPEDICS, LLC

SEAN LAGER, M.D.

Date: ____________ Patient Name: ________________________ Account #: ______________

Reason for today's visit: ____

How long have you had this condition? ______________________________________

Did you have an injury? Yes No If yes, describe: ______________________________

Is the pain constant or does it come and go? ________________________________

When is the pain worse?(circle all that apply) Standing Walking Resting At night Stairs

What activity makes your pain worse? ______________________________________

Do you have difficulty? (circle all that apply) Lifting Reaching Pulling Rotating Pushing

Taking on/off a bra Bending Other If other, describe: ____________________________

Do you have? (circle all that apply) LockingPopping Giving Way Grinding Swelling Burning

Numbness/Tingling Throbbing Stabbing Sharp Dull Cramps Aching Stiffness Radiates

Change in Bowl and/or Bladder habits

Pain Severity: (circle one)None Slight/Occasional Mild Moderate Severe

Does the pain interfere with your daily life? None Almost never Sometimes Almost Always Always

Limp: None Slight Moderate Severe Unable to walk

Support: None Cane, Long walks Cane, Full time One crutch Two crutches/walker Unable to walk

Distance: Unlimited 6 blocks 2-3 blocks Indoors only Bedridden or sitting only

Stairs: Normal up & down Normal up & down w/ rail Normal up; down w/ rail Up & Down w/ rail

Up w/ rail; unable down Unable

Sitting: Any Chair 1hr High Chair ½ hr Unable to sit ½ hour Unable to sit any chair

Socks/Shoes: With ease With difficulty Unable

Transportation: Able to use Unable to use

What Treatment have you received for this condition? Medication Surgery Physical Therapy

Other If other, describe: ____

PLEASE DESCRIBE ANY ADDITIONAL INFORMATION YOU FEEL MAY BE IMPORTANT ABOUT YOUR CONDITION:

______________________ ______________ ______________

Patient/Guardian Signature Relationship Date