SPORTS & ORTHOPAEDIC SPECIALISTS

Craig H. Weinstein, MD, MPH, PC

Date	_____/_____/__20_______	By: ___________

NP ND NC FU PO

PATIENT INFORMATION

Patient's last name: First: Middle:	Likes to be called:	Age:	Sex: ❑ M ❑ F
Lives: (city/community):	Birthplace:		Marital status (circle one): Single / Mar / Div / Sep / Wid
❑ Work ❑ School ❑ Retired ❑ Household			
Name of school/employer:	Type of work:		

SPORTS

Football Baseball Soccer Basketball Tennis Swimming Softball Golf Other:_________________________________ None

❑ Professional ❑ Minor /Semi-pro ❑ Elite ❑ Collegiate ❑ High-school ❑ Jr. organized ❑ Competitive ❑ Recreational

Position:	Team/Club:

REASON FOR APPOINTMENT

Side: ❑ Left ❑ Right ❑ Both	Area (circle): Shoulder / Elbow / Knee / Other (specify) _____________________________________
When did symptoms first start?	How?

Previous treatment (circle): Yes / No If so, by who?

❑ PT/Therapy ❑ Braces ❑ Orthotics ❑ Injections ❑ Anti-inflammatory medications ❑ Other medications ❑ Surgery

If you have had surgery, when (give date)? _____/_____/_______ Where? ____

Surgery performed by (name of surgeon): ____

What was done? ____

INJURY/ACCIDENT

Is this condition the result of?	❑Yes ❑No Accident/Injury?	❑Yes ❑No Workplace injury?	❑Yes ❑No MVA?	❑Yes ❑No Other personal injury?
Have you contacted an attorney? ❑Yes ❑No	Is so, who?			
Is any legal action pending? ❑Yes ❑No				

REFERRAL

Referred by: ❑ Self ❑ Friend ❑ Neighbor ❑ Family ❑ Other Patient ❑ Hospital employee ❑ Doctor

Name of PMD / Referring physician:

Should information be sent to?	❑Yes ❑No Primary care doctor	❑Yes ❑No Referring doctor	❑Yes ❑No Coach	❑Yes ❑No Athletic trainer	❑Yes ❑No Agent