Patient Name: _____

BODY PART #1 (Use second page if you are being seen for more than one body part)

Chief Complaint:

Body Part:	_____	**Laterality:**	☐Left	☐Right

Current pain level (No pain 0 - 10 Severe pain): _____

When did this condition start? _____

Have you ever tried any of the following conservative treatment options?	**Dates/Duration**
Anti-inflammatory medications (such as Aspirin, Ibuprofen, Naproxen, Indomethacin, Meloxicam) Other: _____	☐Less than 3 months ☐More than 3 months
Physical Therapy: ☐At least 6 weeks ☐ 3 months	Date started:
Assistive devices: ☐cane ☐walker ☐crutches ☐wheelchair	Duration:
Knee brace	Duration:
Injections: ☐ Cortisone ☐ Gel/Synvisc How many injections:	Date of last inj:
Exercise program	Duration:
Weight Loss	

Have you ever consulted any other physician regarding this condition?	**Y/N**	**Date(s)**	**Doctors Name & Contact Info**

Recommended Treatment by this Doctor:

_____

Have you ever undergone surgery on this body part?	**Y/N**	**Date(s)**	**Surgeons Name & Contact Info**
Arthroscopic (scope surgery)			
Joint Replacement Component/Prosthesis (If known): _____			
Other Surgery:			

If Yes, please send the **OPERATIVE REPORT** to our office as soon as possible before the date of your appointment. If unable to submit beforehand, please bring the report with you.

Failure to bring in your medical records may delay your course of treatment.

Patient Name: _____

BODY PART #2

Chief Complaint:

Body Part:	_____	**Laterality**:	☐ Left	☐Right

Current pain level (No pain 0 - 10 Severe pain): _____

When did this condition start? _____

Have you ever tried any of the following conservative treatment options?	**Dates/Duration**
Anti-inflammatory medications (such as Aspirin, Ibuprofen, Naproxen, Indomethacin, Meloxicam) Other: _____	☐Less than 3 months ☐More than 3 months
Physical Therapy: ☐At least 6 weeks ☐ 3 months	Date started:
Assistive devices: ☐cane ☐walker ☐crutches ☐wheelchair	Duration:
Knee brace	Duration:
Injections: ☐ Cortisone ☐ Gel/Synvisc How many injections:	Date of last inj:
Exercise program	Duration:
Weight Loss	

Have you ever consulted any other physician regarding this condition?	**Y/N**	**Date(s)**	**Doctors Name & Contact Info**

Recommended Treatment by this Doctor:

_____

Have you ever undergone surgery on this body part?	**Y/N**	**Date(s)**	**Surgeons Name & Contact Info**
Arthroscopic (scope surgery)			
Joint Replacement Component/Prosthesis (If known): _____			
Other Surgery: _____			

If Yes, please send the **OPERATIVE REPORT** to our office as soon as possible before the date of your appointment. If unable to submit beforehand, please bring the report with you.

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OPTIMOTION ORTHOPAEDICS
Phone 407-355-3120 | Fax 407-355-3119

FALL RISK ASSESSMENT

Patient Name: _____ DOB: _____

1. Do you use an assisted device? (walker, cane or crutches) ☐ YES ☐ NO
2. Have you fallen within the past year? ☐ YES ☐ NO
3. Do you feel a buckling sensation? ☐ YES ☐ NO
4. Are you wheelchair or home bound? ☐ YES ☐ NO

Patient Signature: _____ Date: _____

Patient Name: _____ **DOB:** _____

Height: _____ **Weight:** _____

List ALL Medication Allergies	**Reaction**	**Severity (none, mild, moderate, severe)**

Are you a tobacco user? ☐ **Yes** ☐ **No**

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over the counter medications, herbals, vitamin/mineral/dietary supplement. **ALL FIELDS ARE REQUIRED**

Name of Current Medication (example: Aspirin tablet)	**Dosage** (example: 325 mg)	**Frequency/Route of Administration** (example: 3 times daily orally)	**Length of Use**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

PHARMACY INFORMATION: Please indicate the pharmacy you would like your medications sent to:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____