BLACK HILLS
ORTHOPEDIC
& SPINE CENTER
Specializing in what moves you.

Name:_____ Date:_____

Age:_____ Height:_____ Weight:_____

PLEASE CIRCLE affected extremity:

Ankle	Finger	Hand	Toe	Back	Foot
Hip	Wrist	Elbow	Knee	Shoulder	

PLEASE CIRCLE: Left Right Both

When did this injury/problem begin? (Date: Please try to be as specific as possible.) ___/___/___

Please describe how you were injured or what type of problems you are having now.

_____

_____

_____

Describe your level of pain: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Describe your frequency of pain: None 0 1 2 3 4 5 6 7 8 9 10 Severe

Any previous problems or Injuries ☐ Yes ☐ No

If Yes, Please describe:_____

Is this a **WORK** injury? ☐ Yes ☐ No Is Worker's Comp involved? ☐ Yes ☐ No

Is this a **SPORTS** injury? ☐ Yes ☐ No If Yes, what sport?_____

What is your level of play? (Please circle one)

Junior High High School College Professional Recreational

Was this an ACCIDENT? ☐ Yes ☐ No

Type of Accident: ☐ Motor Vehicle Accident ☐ Fall ☐ Other: (Be Specific)_____

Have you been treated previously for this injury? ☐ Yes ☐ No

Physician:_____ City/State:_____

Hospital:_____ City/State:_____

Circle **ANY** previous treatments and/or testing for this problem:

X-rays CT Scan MRI Physical Therapy Injections Surgery

Office use only: Physician/Tech Signature required (initial & date)_____