The Christ Hospital
ORTHOPAEDIC ASSOCIATES
Cincinnati Bone
and Joint Institute

**REASON FOR VISIT:** **Date:** _____

Patient Name: _____

_____
*First* *MI* *Last* *Preferred Name*

DOB: _____ Occupation: _____ Employer: _____

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Pharmacy Name: _____ Phone # _____

Body part being seen for & current symptoms: _____

_____

_____

Side of Body: (*circle*) **Right** **Left** **Both** Date Symptoms Began: _____

Was there an injury? (*circle*) **Yes** **No** Worker's Comp? (*circle*) **Yes** **No**

If so, how did it happen:

_____

_____

What activities or body positions make your symptoms worse?

_____

_____

Have you had prior treatment?

_____

_____