

# New Patient Form

Thank you for choosing our Orthopedic department. We are happy to service you in any way we can. Below we have a form for you to fill out so that **Dr. Moon** and his team can get a better idea of your injury or pain. Please fill out this information to best of your ability, we are looking forward to meeting you soon.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Injury History:

Foot/Toe:  L  R Ankle:  L  R

Is this a work related injury?  YES  NO When did it start? \_\_\_\_\_

Please describe in your own words how the injury occurred?

How does the injury impact your daily life? \_\_\_\_\_

Rate your pain *today* (please circle):

Rest: 1 2 3 4 5 6 7 8 9 10 At its worst: 1 2 3 4 5 6 7 8 9 10

Is the pain:  Constant  Occasional

Have your symptoms been:  Worsening  Stable  Improving

Have you injured this foot/ankle before, is so when? \_\_\_\_\_

Do you have pain when you first get out of bed for the first few steps in the morning?  YES  NO

Can you describe your symptoms (please circle all that apply): Locking/Catching "Giving Out" Popping

Grinding Numbness Tingling Aching Swelling Weakness Sharp Shooting

What makes your symptoms worse (ex: running, jumping, lifting) \_\_\_\_\_

Have you see another provider or been treated for this injury before?

NO  YES..... If YES name of provider and date seen \_\_\_\_\_

Have you had any previous imaging?  X-ray  CT  MRI

Have you had any previous treatment (please describe in detail where applicable)?

Physical Therapy \_\_\_\_\_

Injections \_\_\_\_\_

Bracing/Orthotics \_\_\_\_\_

Medications \_\_\_\_\_

Surgery \_\_\_\_\_

Do you have a history of any of these conditions (circle all that apply)? Diabetes Neuropathy Osteoporosis

Rheumatoid Arthritis Blood Clots Bleeding Disorders Lupus



Official Health Care Partner



Daniel K. Moon, MD  
Orthopedics, Foot and Ankle

Locations:

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