Multi-Care Medical
"Of SW Florida"

__EMC Evaluation
__Initial Ortho Con
__Follow/Up
__Final

NEW PATIENT SLIP AND FALL QUESTIONNAIRE

Today's Date: _____ Past Medical History:

Patient Name: _____

Date of Injury: _____ DOB:_____ Age: _____

BP: _____ Pulse: _____ Height: _____ Weight: _____

Gender: Male ___Female___ Dominant Hand: Right___ Left___ Driver___Passenger___ Seatbelt: Yes__No__

Where did the injury occur? _____

How did the injury happen?

_____

_____

Did the patient go to the hospital? NO___ If yes, where? _____

X-Rays: Y___N___ MRI: Y___N___ Medications: _____ Allergies: _____

Is the patient treating with a physical therapist:_____ or chiropractor: _____

Name of the doctor/facility: _____

Has the patient had any previous injuries/accidents: _____

What does the patient do for a living: _____

INJURED BODY PART:

CERVICAL	THORACIC	LUMBAR	SHOULDER	ELBOW
			L R BLT	L R BLT
WRIST	**KNEE**	**ANKLE**	**FOOT**	**HIP**
L R BLT	L R BLT	L R BLT	L R BLT	L R BLT

FORT MYERS
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Patient Name: _____ Date of Service: _____

Radiographic Findings:

_____

_____

_____

TREATMENT PLAN:

Referrals:

Podiatry	Physical Therapy	Pain Management	Spine Specialist	Hand Specialist

Medications:

Celebrex	Compound Cream	Flexeril	Keflex	Medrol Dose Pak
Mobic	Percocet	Ultram	Vicodin	Zanaflex

DME: _____

CAST: _____ SPLINT: _____

OTHER: _____

XRAY: _____

MRI: _____

CT SCAN: _____

COMMENTS:

_____

_____

FOLLOW UP VISIT: 1 WK 2WKS 3WKS 4WKS 6WKS 3MONTHS PRN

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