



# Trinity Orthopedics

809 W. Harwood Rd., Suite 101  
Hurst, Texas 76054

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## WHAT IS YOUR INJURY:

- Shoulder \_\_\_\_\_ Right \_\_\_\_\_ Left  
Are you right or left handed? \_\_\_\_\_ Right \_\_\_\_\_ Left
- Knee \_\_\_\_\_ Right \_\_\_\_\_ Left
- Other \_\_\_\_\_ (please specify area) \_\_\_\_\_ Right \_\_\_\_\_ Left
- a.) Date of injury \_\_\_\_\_
- b.) Was your injury triggered by? (check all that apply)
- Sport \_\_\_\_\_
- Daily Activity \_\_\_\_\_
- Other \_\_\_\_\_
- No specific trigger can be identified
- c.) How long of you been feeling pain? \_\_\_\_\_

## SYMPTOMS

- Shoulder :** (check all that apply)
- Pain (check intensity): \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe Scale of 0 – 10: \_\_\_\_\_
- When does the pain occur? (e.g., activity, night, etc. \_\_\_\_\_)
- Swelling (check intensity): \_\_\_\_\_ Immediate (less than 4 hours) \_\_\_\_\_ Delayed \_\_\_\_\_ Recurring
- Dislocation- Has this happened before? \_\_\_ Yes \_\_\_ No
- Weakness
- Is motion restricted? \_\_\_ Yes \_\_\_ No
- Other \_\_\_\_\_

- Knee :** (check all that apply)
- Pain (check Intensity): \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe Scale of 0 – 10: \_\_\_\_\_
- When does the pain occur? (e.g., activity, night, etc. \_\_\_\_\_)
- Swelling (check intensity): \_\_\_\_\_ Immediate (less than 4 hours) \_\_\_\_\_ Delayed \_\_\_\_\_ Recurring
- Dislocation – Has this happened before? \_\_\_ Yes \_\_\_ NO
- Weakness
- Is motion restricted? \_\_\_ Yes \_\_\_ No
- Other \_\_\_\_\_

- Other:** (check all that apply)
- Pain (check Intensity): \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe Scale of 0 – 10: \_\_\_\_\_
- When does the pain occur? (e.g., activity, night, etc. \_\_\_\_\_)
- Swelling (check intensity): \_\_\_\_\_ Immediate (less than 4 hours) \_\_\_\_\_ Delayed \_\_\_\_\_ Recurring
- Unstable sensation / looseness
- Popping or “crash” in joint
- Other \_\_\_\_\_

## TREATMENT (check all that apply and provide details)

- None/Rest \_\_\_\_\_
- Brace/Cast \_\_\_\_\_
- Anti-inflammatory/Medications (for this injury – e.g Aleve, Advil) \_\_\_\_\_
- Injection \_\_\_\_\_
- Rehabilitation/Therapy \_\_\_\_\_
- Surgery \_\_\_\_\_
- Return to Activity (& Date) \_\_\_\_\_

## ACTIVITY

- a.) Primary sport \_\_\_\_\_
- b.) What level? (e.g., college, recreational) \_\_\_\_\_
- c.) other sports \_\_\_\_\_
- d.) Runner? \_\_\_\_\_ miles x \_\_\_\_\_ days/week= \_\_\_\_\_ miles/week
- e.) How does injury affect your daily activities? \_\_\_\_\_

## OCCUPATION

- a.) What is your profession? \_\_\_\_\_
- b.) What is your job description? \_\_\_\_\_
- c.) How has your injury affect your job? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_