Western Colorado Spine
Community HOSPITAL

Western Orthopedics & Sports Medicine
Community HOSPITAL

Registration Form

Today's Date:

Patient Name: ______________________________ **DOB:** ________________

Height: ________________ **Weight:** __________

Have you had any of the following? If yes, please provide a date.

Colonoscopy? ____________ Pneumonia Vaccine? ____________ Flu Vaccine? ____________

Occupation: ________________ (or check one): ☐ Unemployed ☐ Disabled ☐ Student

What **body part** are you being seen for today? ______________________________

When did your problem **start?** (If specific date is unknown, please estimate the time of year):

____

How did your problem begin: ______________________________

____

Please circle the items below that best describe your problem:

What are your current symptoms? Pain Numbness Tingling Popping Grinding Locking Bruising Swelling Weakness Decreased range of motion Giving away Sleep disturbance due to pain Other: ______________________________
Your Symptoms Occur: Constantly Intermittently During activity At rest At night
Since the problem began, symptoms are: Worse Unchanged Improving
Rate Your Pain Today: No pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating
What is the quality of your pain? Dull Sharp Aching Stabbing Throbbing Burning Pins & Needles
What makes your symptoms worse?
What makes your symptoms better?
Treatments utilized for problem: Bracing Splint Injection Exercise Physical therapy Ice Heat Decreased activity Crutches Cane Walker Other: ________________ Medication (please circle): Over-the-counter Prescription
Pertaining to this problem you are being seen for today, have you had any: ☐ X-Rays ☐ MRI ☐ CT ☐ EMG's ☐ Other: ________________ If so, where and when:

In Case of Emergency Contact

Name ______________________________

Relationship to Patient ______________________________

Home Phone ______________________

Work Phone ______________________

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Medication List

Please include prescriptions, over-the-counter medication, supplements, vitamins, etc.

Name: ________________________ **DOB** ____________ **Date** ____________

Preferred Pharmacy: ____

Medication Name	**Dosage**	**Diagnosis** (Why are you taking this medication?)

Allergies (Medication or Environment)

□ No known drug allerigies □ No known allergies □ Latex allergy reaction: ____________

Allergy: ____________________ Reaction: ________________________

Allergy: ____________________ Reaction: ________________________

Allergy: ____________________ Reaction: ________________________

Allergy: ____________________ Reaction: ________________________