New Patient Form

Thank you for choosing our Orthopedic department at UCHealth Cherry Creek Medical Center. We are happy to service you in any way we can. Below we have a form for you to fill out so that Dr. Jamieson and her team can get a better idea of your injury or pain. Please fill out this information to the 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