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PATIENT TRAUMA/FRACTURE HISTORY FORM

Name: _____

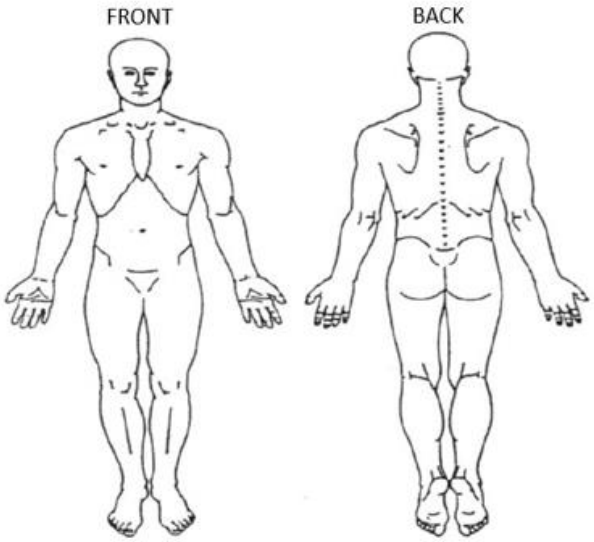
Date of Birth: _____

What/Where is Your Injury: _____

When Did Your Injury Occur: _____

What Happened (Ie. Fall/Sports/Twisting): _____

Where Do You Have Pain?
(Please Indicate on Diagram



What Activities Is It Stopping From Doing (Ie. Sports/Work): _____

Any Previous Injuries Involving That Area: _____

What Treatment(s) Have You Had So Far: _____

What Activities Do You Want To Return To: _____

Is This Injury Workers Compensation / Third Party / Public Liability: ☐ Yes ☐ No

***Medical Conditions & Previous Surgeries:* _____**

_____

***Do You Have a History of Blood Clots, Clotting Disorders or Bleeding Disorders:* _____**

***Medications / Allergies:* _____**

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