Multiple Body Part Form

Please note that listing more than one problem area, does not guarantee the Doctor will be able to see you for all areas on the same day.

Problem #2	Problem #3
Reason for visit?_____☐R ☐L	Reason for visit?_____☐R ☐L
1) Date of onset_____	1) Date of onset_____
2) How did it start? ☐ Same as problem #1 ☐Other_____	2) How did it start? ☐ Same as problem #1 ☐Other_____
3) Severity of pain out of 10 (circle) 0 1 2 3 4 5 6 7 8 9 10	3) Severity of pain out of 10 (circle) 0 1 2 3 4 5 6 7 8 9 10
4) What is the <u>quality</u> of the pain? o Sharp o Dull o Stabbing o Throbbing o Aching o Burning	4) What is the <u>quality</u> of the pain? o Sharp o Dull o Stabbing o Throbbing o Aching o Burning
5) In this area, do you have? o Swelling o Weakness o Numbness o Tingling o Stiffness o Giving away o Catching o Locking	5) In this area, do you have? o Swelling o Weakness o Numbness o Tingling o Stiffness o Giving away o Catching o Locking
6) What makes your symptoms worse? o Standing o Walking o Lifting o Exercise o Twisting o Lying o Bending o Squatting o Kneeling o Stairs o Sitting o Lifting arm above head	6) What makes your symptoms worse? o Standing o Walking o Lifting o Exercise o Twisting o Lying o Bending o Squatting o Kneeling o Stairs o Sitting o Lifting arm above head
7) What makes your symptoms better? o Rest o Heat o Ice Medication:_____ Other: _____	7) What makes your symptoms better? o Rest o Heat o Ice Medication:_____ Other: _____
8) Have you ever had any of these? o Injection o Brace o Therapy o Cane/Crutch	8) Have you ever had any of these? o Injection o Brace o Therapy o Cane/Crutch
9) Have you ever had surgery in this area? ☐Y ☐N Procedure #1 _____ Surgeon/Hospital_____ Date_____	9) Have you ever had surgery in this area? ☐Y ☐N Procedure #1 _____ Surgeon/Hospital_____ Date_____
10) Have you had any testing completed? If so where? o X-ray_____ o MRI_____ o Other_____	10) Have you had any testing completed? If so where? o X-ray_____ o MRI_____ o Other_____