Appointment Date:_____ Dr you are seeing today:_____

Patient Name (print):_____

Age:_____ Height:_____ Weight:_____

What body part are you being seen for today?

☐Foot ☐R ☐L	☐Knee ☐R ☐L	☐Pelvis ☐R ☐L	☐Hand ☐R ☐L	☐Elbow ☐R ☐L	☐Shoulder ☐R ☐L	☐Neck and radiates to ☐Rt arm ☐Lt arm ☐Neither
Toe ☐R ☐L B 2 3 4 5	Ankle ☐R ☐L	Hip ☐R ☐L	Finger ☐R ☐L T 2 3 4 5	Wrist ☐R ☐L	Arm ☐R ☐L	☐Back and radiates to ☐Rt leg ☐Lt leg ☐Neither

***If you have other complaints in addition to the one listed above, please use multiple body part form**

What is the main reason for this visit?

- O Pain
- O Weakness
- O Stiffness
- O Other (please list below)
- O Numbness
- O Swelling
- O Instability

Date of onset_____ Have you had a problem like this before? ☐Yes ☐No

In this section, check ONE BOX which best describes <u>how your problem started</u>. Then answer the questions below the box you checked.

- O **NO INJURY (onset was ☐Gradual or ☐Sudden)**
  Why do you think it started?
- O **INJURY (☐Accident ☐Sport <u>NOT</u> Auto or Work)**
  Date_____, Where and how did it happen?
  What sport?_____
  School_____
- O **INJURY AT WORK** Date_____
  From a ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach
- O **WORK RELATED (BUT <u>NO</u> INJURY)**
  Date_____, how did your job cause this problem?
- O **AUTO ACCIDENT** Date_____, How was your car hit?

Please briefly describe how your injury occurred:

_____
_____
_____
_____
_____
_____
_____

On a scale of 0-10 (10 is the worst) how <u>severe</u> is your pain? (please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain?

- O Sharp
- O Stabbing
- O Throbbing
- O Dull
- O Burning
- O Aching

The pain is:

- O Constant
- O Comes and goes (Intermittent)

Does the pain wake you from sleep?

- O Yes
- O No

Do you have?

- O Swelling
- O Tingling
- O Stiffness
- O Bruise
- O Weakness
- O Locking
- O Catching
- O Giving away
- O Numbness

Since my problem started it is:

- O Getting better
- O Getting worse
- O Unchanged

What makes your symptoms worse?

- O Standing
- O Bending
- O Walking
- O Lifting arm overhead
- O Squatting
- O Lifting
- O Kneeling
- O Lying in bed
- O Exercise
- O Stairs
- O Twisting
- O Sitting
- O Coughing
- O Sneezing

Which make your symptoms better?

- O Rest
- O Heat
- O Ice
- O Elevation
- O Other (please list below)

What medications are you taking now (or previously) for this problem? Does/Did it help?

_____

_____

Have you had any of these treatments?	**Did the treatment help?**	
O Injections	O Yes	O No
O Physical Therapy	O Yes	O No
O Brace	O Yes	O No
O Cane/Crutch	O Yes	O No

Were you referred to our office?

- Yes — If so, by whom were you referred?
- No _____

Where have you been seen for this problem?

- Family Dr. – Name_____ – Date_____
- Specialist – Name_____ – Date_____
- ER / Urgent Care – Name_____ – Date_____

What tests/scans have you had for this problem? Where was the test completed?

- X-Rays_____
- MRI_____
- CAT Scan_____
- Bone scan_____
- Nerve test (EMG/NCV) _____

Have you ever had any surgery for any problem in this same area?

Yes No Please list below:

Procedure #1_____Surgeon_____
Hosp _____Date_____
Procedure #2_____Surgeon_____
Hosp _____Date_____

Current work status?

- Regular
- Disabled
- Light Duty (How long?_____)
- Retired
- Not working due to this problem
- Student (School _____)

What is your current occupation? _____

When is the last date you worked your regular job_____

Are you currently receiving or plan to apply for:

- Disability ☐Yes ☐No
- Workman's Comp ☐Yes ☐No
- Unemployment ☐Yes ☐No

For Workman's Comp / Auto Claims: (if applicable)

Attorney_____ Phone_____

Patient Signature_____ Date_____