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Today's Date: _____

NAME: _____

DOB: _____ **AGE**: _____

HEIGHT: _____ **WEIGHT**: _____

WHO REFERRED YOU TO US?
(Please include address of the physician)

_____
_____
_____

OCCUPATION? _____

ARE YOU CURRENTLY WORKING? YES / NO / RETIRED
____FULL DUTY ____LIMITED DUTY

WHERE IS YOUR PROBLEM?
_____SHOULDER _____ELBOW _____NECK
_____BACK _____HIP _____KNEE _____OTHER_____

WHICH SIDE? RIGHT / LEFT / BILATERAL

DOMINANT ARM? RIGHT / LEFT

PROBLEM(S): (Please check all that apply)
□ No □ Yes Pain
□ No □ Yes Weakness
□ No □ Yes Instability/Giving way/dislocation
□ No □ Yes Stiffness
□ No □ Yes Swelling
□ No □ Yes Catching/locking
□ No □ Yes Other_____

PREVIOUS TREATMENT(S): (Other than surgery)
□ No □ Yes Medications
□ No □ Yes Physical Therapy
□ No □ Yes Injections
□ No □ Yes Bracing
□ No □ Yes Other_____

PREVIOUS SURGERIES FOR THIS PROBLEM (Include dates)
_____
_____

ARE YOU INTERESTED IN SURGERY?
____Yes ____No _____Unsure

HOW SEVERE IS THE PAIN? (0 = none, 10 = severe)
At rest? 0 1 2 3 4 5 6 7 8 9 10
At its worst? 0 1 2 3 4 5 6 7 8 9 10

DO YOU HAVE PAIN AT NIGHT?
_____Yes _____No

DOES IT WAKE YOU FROM SLEEP?
_____Yes _____ No

WHAT MAKES YOUR PROBLEM BETTER?
_____

WHAT MAKES YOUR PROBLEM WORSE?
_____

PLEASE DESCRIBE CURRENT LIMITATIONS?
_____

HAVE YOU HAD ANY PREVIOUS IMAGING STUDIES?
_____X-RAYS _____ MRI _____CT SCAN
Date: _____Location: _____

HOW DID YOU INJURE YOURSELF?
_____NO INJURY _____SPORTS(Which sport?)_____
_____MOTOR VEHICLE ACCIDENT _____WORK

IS THERE A WORKMAN'S COMP CLAIM? Yes / No

DATE OF INJURY: _____

SPORTS LEVEL:
_____NONE _____RECREATIONAL _____COLLEGE _____ PRO

HOW LONG HAVE YOU HAD SYMPTOMS?
_____DAYS _____MONTHS _____YEARS

BRIEFLY DESCRIBE HOW YOUR SYMPTOMS BEGAN:
_____
_____

DIAGNOSIS (if you know or have been told)?
_____

PLEASE INDICATE LOCATION OF PAIN ON THESE FIGURES USING THE FOLLOWING MARKERS

QUALITY OF PAIN:
=== Aching (Dull)
~ ~ ~ Stabbing
+++ Burning
^^^^ Itching
|| || || || || || Numbing
Tingling
**** Radiating