Name: _____ **Date:** _____

Date of birth: _____ **Age:** _____

Occupation: _____ **Hand Dominance:** Right Left

Referring doctor (if any): _____

Why are you seeing the doctor? _____

_____

How long has this problem existed? _____

Is the problem a result of: ___ sports injury ___ work injury ___ accident ___ fall ___ other

please describe: _____

Severity of pain: (circle) (1 - little pain; 10 - severe pain)

0 1 2 3 4 5 6 7 8 9 10

Primary problem(s): (circle) Pain Weakness Loss of Motion Stiffness Instability

Other (please describe): _____

Which of the following cause you pain?: (circle)

Work activities (please describe): _____

Activities of daily living: Dressing Laundry Meal preparation House cleaning

Pain at night/sleeping Pain at rest Other: _____

What makes your symptoms worse? _____

What have you done for this problem to date? **Has it helped?**

Medicine: _____ _____

Physical therapy: _____ _____

Sling / Brace / Cane / Walker: _____ _____

Injections (steroid shot): _____ How many? _____ _____

Surgery: _____ _____

Imaging: (circle) None Xrays MRI CT Ultrasound EMG

What is your goal for today's visit? _____