

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_

Referring doctor (if any): \_\_\_\_\_

Occupation: \_\_\_\_\_

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 symptoms have you experienced?: (circle)

Swelling Popping Locking / Catching Unable to Straighten Out Giving Way

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

Sudden turns Squatting Kneeling Prolonged sitting

Ascending stairs Descending stairs Pain at rest Pain at night

Other: \_\_\_\_\_

What have you done for this problem to date?

Has it helped?

Medication: \_\_\_\_\_

\_\_\_\_\_

Physical therapy: \_\_\_\_\_

\_\_\_\_\_

Brace / Crutches / Cane / Walker: \_\_\_\_\_

\_\_\_\_\_

Injections (steroid shot): \_\_\_\_\_ How many? \_\_\_\_\_

\_\_\_\_\_

Viscosupplementation (lubricant) injections: \_\_\_\_\_

\_\_\_\_\_

Surgery: \_\_\_\_\_

\_\_\_\_\_

Imaging: (circle) None Xrays MRI CT

Ultrasound EMG

What is your goal for today's visit? \_\_\_\_\_