Name: ______________________________ **Date:** ______________

Date of birth: ______________________________ **Age:** ______________

Occupation: ______________________________ **Hand Dominance:** Right Left

Why are you seeing the doctor? ______________________________

____

Is the problem a result of: ___ work or industrial injury ___ motor vehicle accident ___ major fall

_____ sports injury ___ other please describe: ______________________

How long has this problem existed? ______________________________

Primary problem(s): (circle) Pain Stiffness Weakness Numbness Tingling

Other (please describe): ______________________________

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

0 1 2 3 4 5 6 7 8 9 10

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

Activities of daily living: Eating Bathing Using the toilet Dressing

Getting up from chair Pain at night/sleeping Work activities

Other/please describe): ______________________________

Circle any associated symptoms you may have:

History of cancer Unexplained weight loss Current infection Immunosuppression

Major motor weakness Numbness in the groin/buttocks Loss of bowel control

Loss of urinary control (retention, increased frequency, overflow incontinence) None

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

Medicine: ______________________________ ______________

Physical therapy: ______________________________ ______________

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? ______________________________

Please complete this page only. All information in this Worksheet is **Confidential**.