

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)

Reaching overhead Throwing Lifting Dressing Combing hair

Pain at rest Pain at night/sleeping Other: \_\_\_\_\_

Which of the following symptoms have you experienced?: (circle)

Clicking Catching Stiffness Weakness Easily fatigues Neck pain Numb/tingling

What have you done for this problem to date?

Has it helped?

Medications: \_\_\_\_\_

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

Sling: \_\_\_\_\_

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

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

Imaging: (circle) None Xrays MRI CT Ultrasound EMG

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