

GENERAL

Name	<i>Last Name</i>	<i>First Name</i>	<i>M.I.</i>	Today's Date (MM/DD/YYYY) / /
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Age	Which is your dominant hand? <input type="checkbox"/> Left <input type="checkbox"/> Right
Referring Doctor & Phone			Primary Care Doctor & Phone	

Have you been discharged from an inpatient facility in the past 30 days? If yes:

What was your date of discharge?

Were any of your medications changed?

CURRENT PROBLEM

What part of your body are you being seen for today?

Which side? (if applicable)

Left Right

What is the goal of your appointment today?

Pain Management Better Function Better Appearance Return to Work Return to Play Other: _____

How did the problem develop?

When did the problem start: Over Time (Duration: _____) Injury (Date of Injury: _____)

Is this work related? Yes No

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? 0 1 2 3 4 5 6 7 8 9 10

Do you have: Numbness? Tingling? If yes, where:

Have you noticed any weakness? Yes No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? Yes No If yes, explain:

Do your symptoms affect your activities of daily living? Yes No If yes, explain:

Do your symptoms keep you awake at night? Yes No

What treatments have you tried? Injection Physical Therapy Chiropractic Medication: _____ Other: _____

Have any treatments helped? Yes No Please explain:

How many street blocks can you walk?

Do you use a walking device? Cane Crutches Walker Wheel Chair Not Applicable; Don't use a walking device

Describe how you use stairs: Place one foot per step Place both feet on step before proceeding to next Not Applicable; Don't use stairs