

Name: _____

Date: _____

Occupation: _____ Height: _____

Weight: _____ Age _____

1. Reason for visit: _____
2. How long have you had problem? _____
3. Was the onset **gradual** or **sudden** (please circle)? **GRADUAL** **SUDDEN**
4. Did you have an **injury**? **YES** **NO** Date of injury _____
What happened? _____
5. If you have pain, where is it located? _____
6. Describe the pain (please circle): sharp dull electric burning throbbing
7. Do you have any of the following symptoms? (please circle)
Clicking popping locking swelling giving way weakness
numbness/tingling dislocation stiffness looseness of joint
8. How bad is the pain on a scale of 1 - 10 (0 = no pain, 10 = worst pain possible)? _____
9. Do you have pain at night? **YES or NO**
10. What makes your problem **worse**? _____
11. What makes your problem **better**? _____
12. What does your problem limit you from doing? _____
13. Is your problem? Getting **better** getting **worse** staying the **same**
14. Have you had physical therapy? **YES or NO** Did it help? **YES or NO**
15. Have you had injections? **YES or NO** Did they help? **YES or NO**
16. Were you given medicines? **YES or NO** What medicine? _____
17. Did the medicine help? **YES or NO**