

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

What is your age? \_\_\_\_\_

What is your main complaint today? \_\_\_\_\_ Right or Left side?

How long have you had this problem? \_\_\_\_\_

How did the problem start? \_\_\_\_\_

Is the problem related to work? \_\_\_\_\_

What kind of work do you do? Is it: (check one)                      Light      Medium      Heavy

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10 (10 being unbearable), how severe is your pain?(check one)

Other Symptoms/Complaints:

Weakness  
Numbness

Instability  
Clicking

Lock / Catch  
Limited Motion

Discoloration  
Popping

Swelling  
Grinding

How would you describe it?

Aching

Sharp

Burning

Dull

Constant

Intermittent

What sports or recreation do you participate in? \_\_\_\_\_

What school or team do you play for? \_\_\_\_\_

Did you receive treatment elsewhere?    No    Yes: (where)\_\_\_\_\_ (when): \_\_\_\_\_

Did you bring x-rays with you today?    No    Yes    Did you bring an MRI with you today?    No    Yes

Are you taking any medication for this? \_\_\_\_\_

Are you diabetic?    YES    NO    List **Allergies**: \_\_\_\_\_

*I agree that all the information stated above is true and accurate to the best of my knowledge:*

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

***How were you referred to our office today?***

Please check all that apply:

Previous Patient

Family Member/Friend: \_\_\_\_\_

Urgent Care: \_\_\_\_\_

Physician: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Yellow Pages

School: \_\_\_\_\_

Emergency Room: \_\_\_\_\_

Physician Referral Service: \_\_\_\_\_

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