

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: (circle one)                      Light                      Medium                      Heavy

On a scale from 1-10 (10 being unbearable), how severe is your pain?(circle one) 1 2 3 4 5 6 7 8 9 10

Other Symptoms/Complaints:

- |                                   |                                      |   |  |                                   |
|-----------------------------------|--------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Instability | <input type="checkbox"/> Lock / Catch   | <input type="checkbox"/> Discoloration | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Clicking    | <input type="checkbox"/> Limited Motion | <input type="checkbox"/> Popping       | <input type="checkbox"/> Grinding |

How would you describe it?

- |                                 |                                |                                  |                               |                                   |                                       |
|---------------------------------|--------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Dull | <input type="checkbox"/> Constant | <input type="checkbox"/> 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

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:

- |  |  |
|--|--|
| <input type="checkbox"/> Previous Patient            | <input type="checkbox"/> Yellow Pages                      |
| <input type="checkbox"/> Family Member/Friend: _____ | <input type="checkbox"/> School: _____                     |
| <input type="checkbox"/> Urgent Care: _____          | <input type="checkbox"/> Emergency Room: _____             |
| <input type="checkbox"/> Physician: _____            | <input type="checkbox"/> Physician Referral Service: _____ |
| <input type="checkbox"/> Insurance Provider: _____   | <input type="checkbox"/> Other: _____                      |