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Direction of Feed

Non-Op Sports

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.

Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

AGE

AFFECTED SIDE

	left	right	both
collar bone	◯	◯	◯
shoulder blade	◯	◯	◯
shoulder	◯	◯	◯
ribs	◯	◯	◯
upper arm	◯	◯	◯
elbow	◯	◯	◯
forearm	◯	◯	◯

	left	right	both
wrist	◯	◯	◯
hand	◯	◯	◯
fingers	◯	◯	◯
hip	◯	◯	◯
groin	◯	◯	◯
buttock	◯	◯	◯
thigh	◯	◯	◯

	left	right	both
knee	◯	◯	◯
lower leg	◯	◯	◯
ankle	◯	◯	◯
foot	◯	◯	◯
toes	◯	◯	◯

neck ◯ back (spine) ◯ pelvis ◯

ONSET OF SYMPTOMS

Which best describes how your symptoms began? ◯ due to an injury ◯ gradual onset ◯ sudden onset

How long ago did the symptoms begin?

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ >10 ◯

◯ days ago
◯ weeks ago
◯ months ago
◯ years ago

If you do not remember when your symptoms began, please describe how long you have been experiencing the symptoms:

Over the last: 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16+ ◯

◯ weeks
◯ months
◯ years

TIMING

◯ constant
◯ intermittent
◯ occasional
◯ rare
◯ daytime
◯ nighttime
◯ pain causes me to wake up from sleep

other: ________________

HOW DID YOUR PROBLEM START?

◯ at home
◯ at work
◯ during athletic activities
◯ non-vehicle accident
◯ motor vehicle accident
◯ no known cause

other: ________________

If you have had multiple injuries, please describe: ________________

MECHANISM

◯ pulling
◯ twisting
◯ lifting
◯ bending
◯ direct blow
◯ fall
◯ sleep position
◯ repetitive motion
◯ reaching

other: ________________

PAIN

Are you currently experiencing pain? ◯ yes ◯ no

How much pain are you experiencing... 0 = no pain 10 = intolerable

	No Pain	0	1	2	3	4	5	6	7	8	9	10	Intolerable
NOW:	☺	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	☹
AT ITS WORST:	☺	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	☹

QUALITY

◯ sharp
◯ dull
◯ aching
◯ burning
◯ stabbing
◯ throbbing
◯ stinging

other: ________________

ASSOCIATED SIGNS AND SYMPTOMS

◯ stiffness
◯ weakness
◯ locking
◯ catching
◯ numbness
◯ tingling
◯ giving way

other: ________________

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SAMPLE

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Non-Op Sports

Please answer every question

STAFF: Handwritten items must be entered MANUALLY.

PROGRESSION

- worsening
- improving
- resolved
- unchanged
- **other:** ____________________

WHAT MAKES YOUR PAIN WORSE?

- **nothing makes the pain worse**
- lying down
- walking
- standing
- sitting
- climbing stairs
- getting out of a chair
- bending forward
- bending backward
- coughing
- sneezing
- **other:** ____________________

WHAT MAKES YOUR PAIN BETTER?

- **nothing makes the pain better**
- ice
- heat
- rest
- walking
- standing
- sitting
- lying down
- using a brace
- using a splint
- using crutches
- elevation
- stretching
- prescription medication
- over-the-counter medication
- changing activities
- massage
- physical therapy
- injections
- chiropractor
- previous surgery
- medications
- **other:** ____________________

TREATMENT HISTORY

Have you gone to any other locations for today's problem?

- **none**
- Urgent Care
- Emergency Room
- Chiropractor
- Inpatient Evaluation
- Primary Care Provider
- Other Ortho Physician
- Other Physician at this Location
- **other:** ____________________

Have you had any of the following for today's problem?

- X-Ray
- CT Scan
- MRI
- **other:** ____________________

WORK HISTORY

Are you currently working?

- no (If no, when did you last work?): ____________________
- yes
- disabled
- retired

Are you currently on any work restrictions?

- no
- yes (please explain): ____________________

Occupation: ____________________ **Employer:** ____________________

CURRENT SYMPTOMS

Please mark all symptoms you are CURRENTLY experiencing.
Mark all that apply. If no symptoms in a category, please mark "NONE."

Category			
GENERAL	trouble sleeping recent weight loss	fatigue loss of appetite	NONE
CARDIOVASCULAR	chest pain	palpitations	NONE
SKIN	frequent rashes skin ulcers	lumps non-healing wound	NONE
EAR / NOSE / THROAT	hearing loss	hoarseness trouble swallowing	NONE
ENDOCRINE	cold intolerance	heat intolerance	NONE
EYES	vision loss	blurred vision double vision	NONE
GASTROINTESTINAL	heartburn nausea	vomiting blood in stool	NONE
GENITOURINARY	blood in urine	painful urination	NONE
HEMATOLOGIC / LYMPHATIC	easy bruising	easy bleeding	NONE
NEUROLOGICAL	headaches	dizziness numbness	NONE
PSYCHIATRIC	feeling anxious	feeling depressed	NONE
RESPIRATORY	chronic cough	shortness of breath	NONE

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