Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions. Do not fold this form.	Shou Please answer e	every questio	in		<b>STAFF:</b> Hand must be ente		
	PLEASE PRINT PATIEN	IT'S LAST NAME					
Marking Instructions							
Please use a #2 pencil.	PLEASE PRINT PATIEN	IT'S FIRST NAME	PA	TIENT'S DATE OF	BIRTH	A	GE
ill in the complete oval as shown •			Mo	onth Day	Year		
AFFECTED SIDE							
_		right both					
	shoulder						
ONSET OF SYMPTOMS					🔵 gra	dual ons	et
Which best describes how your symptom	ms began?	🔵 du	ie to an	injury	-	lden ons	
How long ago did the symptoms begin?				days ago			
1 2 3 4 5	6 7 8 9	10 >10	$\bigcirc$	weeks ago			
			$\bigcirc$	months ago years ago			
If you do not remember when your sym	ptoms began, please d	escribe how			xperiencing	g the syn	nptoms
			07				•
Over the last: $\bigcirc 1 \bigcirc 2 \bigcirc 3 4 \bigcirc 2$	6789	10 11 1	2 13	14 15 1	6+ 🤇	) weeks	
Over the last: O O O O	$\circ \circ \circ \circ$	$\circ$	$\supset \bigcirc$	$\bigcirc$		) montł	าร
TIMING						) years	
constant	🔿 rare		$\bigcirc$	pain causes n	ne to wake i	un from	sleen
intermittent	daytime		$\bigcirc$	other:			ысер
occasional	<ul> <li>nighttime</li> </ul>						
HOW DID YOUR PROBLEM START?							
🔵 at home	— non-vehicle accid	dent		other:			
🔵 at work	<ul> <li>motor vehicle ac</li> </ul>	cident					
<ul> <li>during athletic activities</li> <li>If you have had multiple injuries, pla</li> </ul>	no known cause case describe:						
MECHANISM							
	O direct blow		$\bigcirc$	reaching			
twisting	<ul> <li>fall</li> </ul>		$\bigcirc$	other:			
◯ lifting	sleep position						_
bending	repetitive motion	n					_
PAIN Are you currently experiencing pain?				🔘 yes	C	) no	
How much pain are you experiencing	0 :	= no pain	10 = into	olerable			
NOW:	$\bigcirc \bigcirc \bigcirc \bigcirc \bigcirc \bigcirc \bigcirc 1 2$	$\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$	5 6	$\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$	9 10	Intolerable	
AT ITS WORST:	$\bigcirc \bigcirc \bigcirc \bigcirc$	$\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $3$ 4	5 6	$\overline{)}$	9 10	$\overline{\mathbf{i}}$	
QUALITY	n V 1 2			, 3	10	Intolerable	
🔵 sharp	burning		$\bigcirc$	stinging			
🔵 dull	stabbing			other:			
aching	throbbing						_
ASSOCIATED SIGNS AND SYMPTOMS				-1.1.			
stiffness	catching		$\odot$	giving way			
<ul> <li>weakness</li> <li>locking</li> </ul>	<ul> <li>numbness</li> <li>tingling</li> </ul>			other:			
	VUISIIIS						

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	ice, follow the printing instruction	shoulder			ndwritten items tered <mark>MANUALLI</mark>
	Do not fold this form.	Please answer every question	4	-	
PROGRESSI	ION				
🔵 worseni	ing	resolved		other:	
🔵 improvi	ing	unchanged			
WHAT MAI	KES YOUR PAIN WORSE?				
🔿 nothing	g makes the pain worse	Climbing stairs	$\bigcirc$	sneezing	
Iying do	-	getting out of a chair		5	
walking		<ul> <li>bending forward</li> </ul>		other:	
standing		<ul> <li>bending backward</li> </ul>		other	
Sitting	Б	<ul> <li>coughing</li> </ul>			
	KES YOUR PAIN BETTER?				
	g makes the pain better	using a brace	$\bigcirc$	massage	
$\supset$ ice	, makes the pair better	<ul> <li>using a blace</li> <li>using a splint</li> </ul>		physical therapy	
heat		<ul> <li>using crutches</li> <li>elevation</li> </ul>		injections	
rest				chiropractor	
walking		stretching		previous surgery	
standing	g	prescription medication		medications	
sitting		over-the-counter medication		other:	
Iying do		Changing activities			
	IT HISTORY		_		
	one to any other locations			Other Ortho Physician	
none	(	Chiropractor		Other Physician at this L	ocation
Urgent		Inpatient Evaluation		other:	
	ency Room	Primary Care Provider		other:	
→ X-Ray WORK HI	STORY STORY working?				
X-Ray	CT Scar STORY rrently working? ) (If no, when did you last work?):	MRI	) disab ) retire		
X-Ray	CT Scar STORY rrently working? (If no, when did you last work?): s rrently on any work restric	m MRI			
X-Ray	CT Scar CT	h MRI	exper	iencing.	
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