Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Today's Visit

Please answer every question.

STAFF: Handwritten responses 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

Email: _____

CURRENT PROBLEM

What is the reason for your visit today?

- ◯ pain
- ◯ numbness
- ◯ weakness
- ◯ stiffness
- ◯ swelling
- ◯ instability
- ◯ popping / grinding
- ◯ other (please specify): _____

When did the injury occur or when did your symptoms begin? _____

Where did the injury / symptoms occur?

- ◯ at home
- ◯ at work
- ◯ at school
- ◯ car accident
- ◯ during sports / recreation
- ◯ other (please specify): _____

Are you claiming this as a work related injury? ◯ yes ◯ no

How did the injury / symptoms occur?

- ◯ sudden / traumatic
- ◯ lifting / bending
- ◯ gradual onset
- ◯ previous injury
- ◯ recurrence
- ◯ injury related to a fall
- ◯ other (please specify): _____

PAIN CONCERNS

Are you currently experiencing pain? ◯ yes ◯ no (If the answer is no, please skip ahead to the next page.)

Is the pain: ◯ sharp ◯ burning ◯ dull ◯ aching

Is the pain: ◯ occasional ◯ continuous

Is the pain: ◯ improving ◯ worsening ◯ unchanged ◯ comes and goes

Do you wake up at night with this pain? ◯ yes ◯ no

What makes your pain BETTER? (Mark all that apply.)

- ◯ medication
- ◯ physical therapy
- ◯ massage
- ◯ elevation
- ◯ walking
- ◯ exercise
- ◯ standing
- ◯ sitting
- ◯ sleeping
- ◯ rest
- ◯ ice
- ◯ heat
- ◯ other (please specify): _____

What makes your pain WORSE? (Mark all that apply.)

- ◯ bending
- ◯ squatting
- ◯ kneeling
- ◯ walking
- ◯ driving
- ◯ running
- ◯ sleeping
- ◯ weather
- ◯ employment / work
- ◯ sitting for long periods of time
- ◯ standing for long periods of time
- ◯ other (please specify): _____

Where is the pain located? (Mark all that apply.)

	left	right	both sides
collar bone	◯	◯	◯
shoulder	◯	◯	◯
upper arm	◯	◯	◯
elbow	◯	◯	◯
lower arm	◯	◯	◯
wrist	◯	◯	◯
hand	◯	◯	◯
fingers	◯	◯	◯
pelvis	◯	◯	◯
hip	◯	◯	◯

	left	right	both sides
thigh	◯	◯	◯
knee	◯	◯	◯
lower leg	◯	◯	◯
ankle	◯	◯	◯
foot	◯	◯	◯
toes	◯	◯	◯
back	◯	◯	◯
neck	◯	◯	◯

◯ other (please specify): _____

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PREVIOUS TREATMENT

Have you had any previous difficulty or injury to this area?

○ no ○ yes (please specify): _____

Have you been seen by another doctor for this injury / condition?

○ no ○ yes (name): _____

When did you see the other doctor? (If applicable.)

○ in the last month ○ 1-3 months ago ○ 3-6 months ago ○ 6-12 months ago ○ over 1 year ago

Have you had any of the following for this problem? (Mark all that apply.)

○ x-rays ○ MRI ○ other (please specify): _____
○ CT scan ○ bone scan ○ **NONE**

Have you received any of the following treatments? (Mark all that apply. If none, mark "**NONE**".)

○ injection	**If yes, did it help?**	○ yes	○ no
○ medications	**If yes, did it help?**	○ yes	○ no
○ physical therapy	**If yes, did it help?**	○ yes	○ no
○ surgery	**If yes, did it help?**	○ yes	○ no

○ other (please specify): _____

○ **NONE**

CURRENT SYMPTOMS

Please indicate if you are CURRENTLY experiencing any of the following.

Mark all that apply. If no symptoms in a category, mark "**NONE**."

GENERAL

○ sweats ○ chills ○ fevers ○ weight loss ○ appetite loss ○ fatigue (always tired) ○ **NONE**

MUSCULOSKELETAL

○ gout ○ arthritis ○ stiffness ○ joint swelling ○ joint pain ○ muscle aches ○ back pain ○ muscle cramps ○ muscle weakness ○ loss of strength ○ **NONE**

SKIN

○ suspicious lesions ○ poor wound healing ○ dryness ○ psoriasis ○ changes in color of skin ○ changes in nail beds ○ unusual hair distribution ○ **NONE**

NEUROLOGIC

○ headaches ○ weakness ○ fainting ○ poor balance ○ numbness ○ tingling ○ seizures ○ tremors ○ falling down ○ memory loss ○ visual disturbances ○ disturbances in coordination ○ **NONE**