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

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

1 2 3 4 5 6 7 8 9 10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Other Symptoms/Complaints:

☐ Weakness	☐ Instability	☐ Lock / Catch	☐ Discoloration	☐ Swelling
☐ Numbness	☐ Clicking	☐ Limited Motion	☐ Popping	☐ 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

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	☐ Yellow Pages
☐ Family Member/Friend: _____	☐ School: _____
☐ Urgent Care: _____	☐ Emergency Room: _____
☐ Physician: _____	☐ Physician Referral Service: _____
☐ Insurance Provider: _____	☐ Other: _____