PATIENT HISTORY

DATE:_____

NAME:_____ DOB:_____

IF YOUR SYMPTOMS ARE THE RESULT OF AN INJURY, COMPLETE THE FOLLOWING:
Type of Injury: Work___ Auto___ Home___ Other (Explain):_____
Date of Injury: _____ Side of Injury: L___ R___
How it happened:_____
Are you currently off work due to this injury?_____ If yes, as of what date?_____

HISTORY AND PRESENT ILLNESS
Date your symptoms began:_____ Describe your symptoms:_____

Is your pain (circle that apply): Sharp Dull Aching Stabbing Burning Tingling Numb

For the knee (circle that apply): Swell Lock in Position Give out

For the shoulder: 0-Unable to do 1-Very difficult to do 2-Somewhat difficult 3-Not difficult

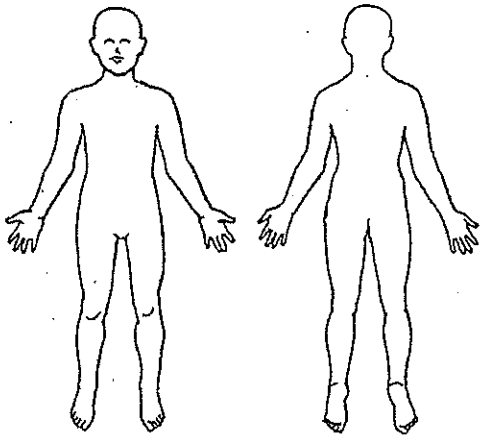
ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your side	0 1 2 3	0 1 2 3
3. Wash back/do up bra	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs above the shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work/list:_____	0 1 2 3	0 1 2 3
10. Do usual sport/list:_____	0 1 2 3	0 1 2 3

Severity: Rate 1 (low) to 10 (high) ____ Your pain is: Constant Daily Weekly Monthly Other_____
Rate your pain today (Mark the line): No pain |_|_|_|_|_|_|_|_|_|_| pain as bad as can be

What treatment have you had so far? How long/many weeks?
Physical Therapy:_____ Brace/Collar/Splint:_____ Testing/where:_____
Injection/Surgery:_____ Medication (type):_____
Treatment by another Doctor:_____

Please mark the areas on your body where you feel the following sensations using the symbols below:

* Numbness . Pins/Needles x Burning / Stabbing



What makes it worse?
_____
_____
_____
_____

What makes it better?
_____
_____
_____
_____