



name _____ age _____ birthdate _____ height _____ weight _____

consultation requested by: _____ worker's compensation case legal case

Are you: right handed left handed male female occupation _____

Why are you here today? _____

When did the problem start? _____

How did it happen? _____

What makes it worse? _____

What makes it better? _____

For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING OTHER _____
- On a 0 to 10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER _____

Have you ever experienced any injury to or symptoms involving this body part in the past? Yes No

If so, please provide details: _____

Have you had any treatment for this problem? **NONE** medication therapy splinting injection surgery

Medical History: Do you currently or have you ever had any of the following? **NONE**

- anemia arthritis asthma / COPD bleeding disorder blood clots
- cancer chronic pain syndrome circulatory problems depression diabetes
- drug / alcohol problem gout fibromyalgia heart disease hepatitis
- high blood pressure HIV / AIDS kidney disease osteoporosis psychiatric illness
- pregnancy (current) reflux / heartburn seizures sleep apnea/ CPAP stomach ulcers
- stroke thyroid problems other / details _____

Medications: **NONE** additional sheet attached

| Medication (include over the counter medicines and nutritional supplements) | Reason Used | Dose |
|---|-------------|------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |