Name: ____ **DOB:** _________________ **Date:** _____________

What brings you in today?____

How long have you had this issue?____

Do you have any of the following?

- ☐ Swelling
- ☐ Locking
- ☐ Catching
- ☐ Grinding
- ☐ Popping
- ☐ Bruising
- ☐ Other___________________________________

Did you have a recent fall or injury? Yes or No

If yes please briefly explain:____

____

Did you experience any of the following with the injury?

- ☐ Snap
- ☐ Pop
- ☐ Pain
- ☐ Swelling
- ☐ Other____________________________________

Does any of the following aggravate it?

- ☐ Bending
- ☐ Walking
- ☐ Daily activities
- ☐ Exercise_________________________________
- ☐ Other____________________________________

Please turn over for page 2. Thank you

Is there anything that helps relieve the pain?

- ☐ Ice
- ☐ Medication - Name of Medication: ____
- ☐ Resting
- ☐ Heat
- ☐ Other___________________________________

When is the pain the most severe?

- ☐ Morning
- ☐ Nighttime
- ☐ During activity
- ☐ Always the same
- ☐ Other___________________________________

Does your pain radiate anywhere else?____

Do you ever use any of the following though out your day?

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other__________________________________

If you do use one of the above, when and how often?____

Have you had any prior treatments, medications, or X-rays of this body part? Yes or No

If yes, please briefly explain:____

____

____