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:_____

_____

_____