

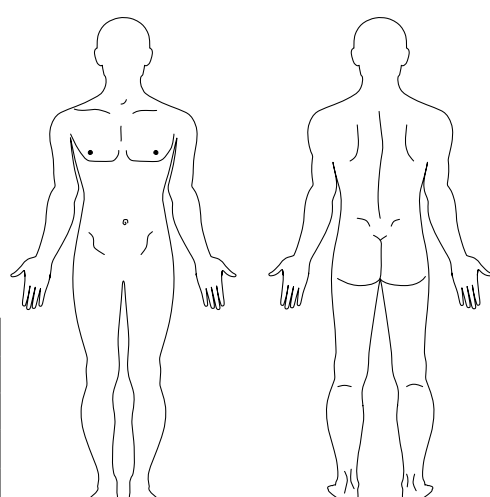
Patient Name	Date of Birth
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Injury Details	
Type of Injury	Date of Onset
How did the injury occur?	
List any medications you are presently taking (if any):	
Have you had x-rays taken for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Pain Description	
Which of the following best describes your pain? (check one) <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Shooting	
Which of the following best describes the frequency of your pain? (check one) <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	
What makes your pain feel worse? (check all that apply)	<input type="checkbox"/> Lifting <input type="checkbox"/> Leaning <input type="checkbox"/> Dressing <input type="checkbox"/> Climbing
	<input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Reaching
	<input type="checkbox"/> Driving <input type="checkbox"/> Bending <input type="checkbox"/> Stooping <input type="checkbox"/> Laying Down
What makes your pain feel better?	

Please rate the level of pain you have experienced over the past 30 days:	No Pain	Moderate Pain	Worst Pain								
	0 1 2 3 4 5 6 7 8 9 10										
What number on the pain scale best describes your pain right now ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What number on the pain scale best describes your worst pain over the past 30 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What number on the pain scale best describes your least pain over the past 30 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

General Medical History	
Do you have a history of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a pacemaker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have bowel/bladder problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any other relevant past medical or orthopedic history.	

Symptom Diagram											
Using the diagram, please indicate the location and type of symptoms you are experiencing.											
Use the symbols from the diagram key below to indicate the location and type of symptoms.											
<table border="1" style="width:100%"> <tr> <th colspan="2" style="background-color:#cccccc;">DIAGRAM KEY</th> </tr> <tr> <th style="width:30%">SYMBOL</th> <th>SYMPTOM</th> </tr> <tr> <td style="text-align:center">X</td> <td>pain</td> </tr> <tr> <td style="text-align:center">-----</td> <td>numbness</td> </tr> <tr> <td style="text-align:center">- - - - -</td> <td>tingling</td> </tr> </table>	DIAGRAM KEY		SYMBOL	SYMPTOM	X	pain	-----	numbness	- - - - -	tingling	
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