

In order to assist your physician in evaluation of your problem, please answer all questions to the best of your ability. If you are unsure of your response, discuss it with the doctor.

NAME: _____ **DATE:** _____

Occupation: _____

I. NATURE OF COMPLAINT: **Pain** **Weakness** **Tingling** **Aching**

Dizziness **Clumsiness** **Nausea**

Date of Onset: _____ Duration: (steady) _____ (on and off) _____

Additional comments: _____

Location of symptoms: _____

II INFORMATION ON COMPLAINT:

X-Rays: Yes No Where taken: _____

Scan: Yes No Where taken: _____

MRI: Yes No Where taken: _____

Please list **ALL** medications you are taking: _____

Name of physician who has treated you for this problem: _____

If hospitalized, where: _____

Drug Allergies: _____

Previous orthopaedic problems or surgery: _____

III FOR INJURY ONLY:

Place where occurred: _____

Date and time injury occurred: _____

Initial treatment: _____

Work time lost? Yes No Number of days: _____ Last day worked: _____

Describe how injury occurred: _____

NAME: _____ **DATE:** _____

Please fill out the pain drawing. This will tell us where your pain is now and something about it. Mark the areas on your body where you feel the pain. Use the following patterns:

Draw arrows if the pain shoots or travels. NUMBNESS: --- PINS & NEEDLES: ooo

BURNING: xxx STABBING: /// ACHING: +++ OTHER: ***

