Patient Name:_____ **Date:**____/____/_____

Reason for Your Visit

1. What is the reason for your visit?_____
2. Have you had this problem in the past? Yes/no If yes, how many times?____ When?_____
3. When did you first notice these symptoms?_____
4. What were you doing when you first noticed these symptoms?_____
5. Before you began to suffer from this problem, was there an earlier accident, injury, or condition that could have brought this about, or may be related to it (e.g. fall, auto/work/sports injury, repetitive motion at work)? Yes/no
   If yes, explain:_____
6. Is the pain/symptoms getting progressively (circle): worse better staying the same
7. Do you have difficulty (circle all that apply): sitting standing walking bending sleeping driving
8. What specific activities/movements increase your symptoms?_____
9. Have you tried anything on your own that makes you feel better?_____
10. Have you consulted any other physicians for this condition? Yes/no
    If yes, name/address/phone # of physicians:_____
11. If yes to #10, did you receive any treatment? Yes/no Explain:_____
12. Describe your pain (circle 1 or more): sharp stabbing dull achy throb shooting burn stretching
13. Is your pain constant or occasional?_____
14. The symptoms are worse (circle): in the morning as the day goes on at rest with activity
15. Do you experience any (circle): numbness tingling muscle cramps stiffness swelling other
    Explain:_____
16. Have you experienced any pain/numbness/tingling that travels down your arms and/or legs? Yes/no
    If yes, does it travel to (circle): shoulders elbows hands fingers thighs knees feet toes
17. Rate the severity of your pain by making a mark on the following line (0=no pain and 10=worst pain imaginable):
    0----------10
18. Does anyone else in your family have this same, or a similar, symptom? Yes/no
    If yes, who and when:_____
19. Does this condition interfere with your work duties? Yes/no Explain:_____
20: Does this condition interfere with your family life? Yes/no Explain:_____
21. Does this condition interfere with your social life? Yes/no Explain:_____
22. Does this condition create stress for you? Yes/no Explain:_____
23. Have you become discouraged about getting this problem handled? Yes/no
24. Are you ready to get help for this problem? Yes/no