NAME:______________________________ AGE IN YEARS:___________________ DATE:______________

DOB________________

(CHECK/FILL OUT ALL THAT APPLY)

Who referred you to our practice? ____

What is the reason for today's visit? ____

____

Which side is affected? ◻ **LEFT** ◻ **RIGHT** ◻ Both sides

[1] *Were you seen in Emergency Room/Convenient Care Facility?* ◻ YES ◻ NO

If yes, where?_____________________________ Treatment Given:__________________________________

Was there an **INJURY/ACCIDENT** or activity associated with the onset of symptoms? ◻ YES ◻ NO

If Yes, please describe:____

Did you have any pain/symptoms prior to injury? ◻ YES ◻ NO

[2] *Where is the location of your pain/symptoms:*

◻ SHOULDER ◻ ARM ABOVE ELBOW ◻ ELBOW ◻ FOREARM ◻ WRIST

◻ HAND ◻ FINGERS (specify):______________________________ ◻ THE WHOLE ARM

◻ OTHER:____

[4] *How long have you had these symptoms?:* ____

[5] *Describe onset of symptoms*: ◻ Gradual onset of symptoms over time ◻ Sudden/abrupt start of symptoms

[6] *Describe symptoms since they started:*

◻ Getting worse ◻ Getting better/Improving ◻ Have remained the same

[7] *Describe the quality of your pain:*

◻ NO PAIN ◻ Rest pain ◻ Night pain ◻ Sharp pain ◻ Dull pain

◻ Shooting pain ◻ Burning pain ◻ Throbbing pain ◻ Aching pain

[8] *Describe the frequency of your pain:*

◻ Constant ◻ Present most of the time ◻ Pain only present occasionally

[9] *How bad is your pain from **0 to 10 (0 is no pain, 10 being the worst pain):***

Pain at its worst ___________

DOCTOR'S SIGNATURE:______________________ PATIENT SIGNATURE:____________________

*NAME:*___________________________________

[10]*Is there any numbness or tingling present?* ☐ YES ☐ NO

Location of numbness/tingling:____

Any activities associated with numbness/tingling?____

[11]*If YES, check one of the following:*

☐ Constant Numbness/tingling ☐ Numbness/tingling present most of time

☐ Occasional Numbness/tingling

[12]*Please check all associated symptoms that apply:*

☐ No pain

☐ Pain associated with daily activities

☐ Pain with gripping activities

☐ Pain with overhead activities

☐ Pain with reaching around back

☐ Pain with turning door knobs

☐ Difficulty sleeping at night due to symptoms

☐ Stiffness (Where?)_________________________________

☐ Weakness (Where?)_________________________________

☐ Redness (Where?):________________________

☐ Swelling (Where?):_______________________

[13]*What makes the problem worse:*

☐ Lifting ☐ Cold weather ☐ Exercise ☐ Driving ☐ Movement

☐ Sleeping ☐ Gripping ☐ Reading ☐ Other:_____________________________

[14]*What makes the problem better:*

☐ Rest ☐ Cold Therapy ☐ Heat therapy ☐ Bracing ☐ Anti-inflammatory medication

☐ Nothing makes it better ☐ Other:____

[15]*Have you had any of the following treatments? (Check all that apply):*

☐ NO PRIOR TREATMENT ☐ Anti-inflammatory medication ☐ Pain (narcotic) medication ☐ Bracing

☐ Injections (# of injections?) _____________ ☐ Physical therapy ☐ Ice or Heat

☐ Prior surgery in affected area (When?)____

☐ Other: ____

DOCTOR SIGNATURE: ____________________ PATIENT SIGNATURE:______________________