Patient Evaluation

Patient Name:_____ **DOB:**_____ **Date:**_____

Is this due to a non-work related injury? ☐ Yes ☐ No

If yes, when? _____ where?_____ what time?_____

Is this due to a work injury? ☐ Yes ☐ No **If yes, Date of Injury** _____

Has this been reported to your employer? ☐ Yes ☐ No **Are you still working?** ☐ Yes ☐ No

Problem being seen for today: _____ ☐ Right ☐ Left

What symptoms are you experiencing?_____

_____

How long have you had this problem?_____

Have you experienced this problem in the past? ☐ Yes ☐ No If yes, please describe: _____

_____

What makes your pain *worse?*_____

_____

What makes your pain *better?*_____

Have seen another physician for this problem? ☐ Yes ☐ No Please explain: _____

_____

Have you had prior treatment for this problem? ☐ Yes ☐ No Please explain: _____

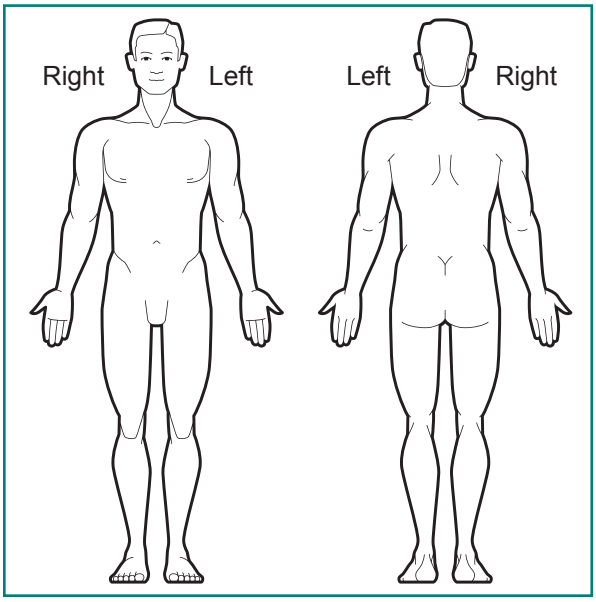
_____

Had any prior testing? (Please check) ☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ DEXA (Bone scan)

If yes, Where? _____ When? _____

On the illustration below, please use the following symbols to explain your symptoms:

Aching ^ ^ ^ ^ Sharp < < < < Burning / / / / Dull Ache = = = = Numbness x x x x Pins/Needles * * * *



Pain Scale (Please Circle)

0 **No pain**
1
2
3
4
5 **Moderate Pain**
6
7
8
9
10 **Severe Pain**

Height _____ Weight _____

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