

Name: \_\_\_\_\_ Are you: MALE / FEMALE Date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you: Left Handed / Right Handed

What problem are you here for today? (Include whether it is left, right, or both if appropriate)

How long have you had this problem? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years  
If known, what date did the problem start?

Describe what caused the problem. (Work, School, Accident, etc)

What are your current symptoms?

What makes it: **BETTER-**  
**WORSE-**

Did you go to the: *ER Family doctor Pediatrician Specialist Work comp. doctor*  
If known, what was his/her name?

Have you had: *X-Ray MRI* If so, **when**?

What medicines are you taking for this problem?

Have you used: *Splint Crutches Cast Ice Heat Brace Walking boot*

Did you do physical therapy? **YES / NO** When? Did it help?

Have you had surgery for this problem? **YES / NO**  
If YES, please list:

Have you had similar problems in the past? **YES / NO**  
If YES, please explain:

What is your occupation?  
Is your current problem work related? **YES / NO** If YES, was it reported? **YES / NO**  
Are you currently working? **YES / NO** If NO, please explain:

If you are a STUDENT: School: Grade:

What are your activities / sports / hobbies?

What do you hope to get out of today's visit?

Who referred you to our practice?