Patient Name: ______________________ **Age:** ________ **Date of Injury:** ____________

Medications: ____

Where is your problem? Hip Knee Elbow Shoulder Back Ankle Wrist Other

How long have you had symptoms? _______ Days _______ Mo _______ Yrs

Which side? (if applicable) Left Right Both

Please check all that apply:

- ☐ Pain
- ☐ Numbness
- ☐ Instability / Giving Way
- ☐ Dislocation
- ☐ Stiffness
- ☐ Swelling
- ☐ Other ______________________

How did you injure yourself? (check all that apply)

- ☐ Automobile Accident
- ☐ Sports (Please describe) ______________________
- ☐ Work / Job
- ☐ Other (Please describe ______________________

Is this a workers comp Claim? Yes / No

Previous treatments to the area ______________________

How severe is the pain?
0 = none, 10 = severe

At rest 0 1 2 3 4 5 6 7 8 9 10

At work 0 1 2 3 4 5 6 7 8 9 10

Previous surgeries w/ dates ______________________

Have you had any previous imaging studies?

X-rays MRI CAT Scan

Dates __________ __________ __________

Pain at night? Yes / No

Does it wake you? Yes / No

Are you currently working? Yes / No / Retired

Are you on light duty? Yes/ No

What makes your problem better? ______________________

What makes your problem worse? ______________________

Prior diagnosis for this problem? ______________________

THE INFORMATION NEEDED BELOW IS THE ACTUAL CARD HOLDERS INFORMATION

Name ______________________ **DOB** __________ **Cell** __________

Relation to Patient __________ **DL #** __________ **Home** __________

Employer ______________________ **SS #** __________ **Work** __________

Primary Ins __________ **Phone** __________ **Group #** __________ **ID** __________

Secondary Ins __________ **Phone** __________ **Group #** __________ **ID** __________

I have received the Privacy Notice and have been given the opportunity to review its contents

______________________ __________