Are you a new patient: Yes No

What is the problem you are seeing us for today(example, knee, hip etc) _____

What side of the body is the problem on (circle one) Left Right Bilateral

Is the problem you are seeing us for today due to an injury (circle) Yes No

If the problem is due to an injury what was the date of the injury (Month/day/Year or Month/Year)_____

If the problem is not do to an injury approximately when did it start?_____

Was the injury due to any of the following: _____ Auto Accident _____ Sports Injury
_____Workers Comp _____Fall or other injury

If you are a student what school do you attend _____
If you are a student what sports do you play:_____

Please rate your Pain:
____0-1 No pain to very little
____2-3 Mild pain, annoying
____4-5 Nagging pain, uncomfortable
____6-7 Miserable, Distressing
____8-9 Intense
____10 Worse pain ever felt, Unbearable

Please Describe your pain(Mark **all** that you are having) ___Constant pain ____intermittent pain
____Aching ____Radiating ___Burning ____Throbbing
____Dull ____Stabbing ___Soreness ____Sharp
____Shooting ____other_____ ____NONE

Are you having any of the following:
____Weakness ____Stiffness in the joint ____loss of Motion ____Locking in the joint
____Catching in the joint ____Popping/Clicking in the joint ____Grinding ____Giving out
____Spasms ____Numbness ____Tingling ____NONE

Are you having any swelling Yes or No and if so was the swelling ___Immediate ____Gradual

Are you having any trouble with any of the following:
____Walking ____Steps ___Sitting ____Laying ___Sleeping ___Standing
____Trouble with Activities of Daily Living (Examles: Bathing, Clothing self, etc)
If so, please describe _____

Have you tried any of the following for the problem you are seeing us for today:
___Rest x1week ____Rest x2-3 weeks ___Rest x 4-6 weeks ___Physical Therapy
___Home Exercises ____ATC treatments ___Aquatic Therapy ___Spina (IDD)Therapy
___Chiropractic Care ____Home stim or Tens unit ____Home Traction ___Ice ___Ace Wrap
____Heat ___Over the counter Bracing ___Prescription brace ____Taping
____Over the counter orthotics/shoe inserts ___Presciption/Custom orthotics/shoe insert
____Injections ____Medications

Did any of the above give relief? If so please circle the ones that helped.

Have you had any of the following done for the problem you are seeing us for today:
___MRI ___X-rays ___CT ___EMG/NCV ____Ultrasound __Other_____
___PRP ___PRP/AFG ___BMAC ___Tenex

If so where did you have those done at?_____
And approx. when were they done_____