Current Problem Information

Name: ____ DOB: ____/_____/________

Name of current problem ____________________________i.e. left hand pain, right ankle injury etc.

When did your problem begin? Date: ______/______/_____ or _______days, weeks, months, years ago

Is this a work related injury? Yes No < **(please circle one)**

Is this an automobile accident? Yes No < **(please circle one)**

Please describe the symptoms or injury:

____

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Description of symptoms: (please circle and/or fill in blanks below)

Location: (Left/Right) Body Area: ____________________pain radiates to: ______________________

Pain quality: Sharp, dull, throbbing, stabbing, stinging, burning, other ___________________________

Severity on a scale of 1-10: 0 1 2 3 4 5 6 7 8 9 10

Duration: Constant, Intermittent, length of time symptoms last ___________, time between symptoms ___________ minutes ________, hours________, day's ________, week's _______, month's _________

Timing: Exercise, nightly, mornings, evenings, other ____

Trends: Improving, worsening, stable and not changing, recurrent, other _________________________

Modifying factors: What makes it better? ____

What makes it worse? ____

Better positions: Sitting, standing, walking, lying on back, lying on side L/R, or position doesn't matter

Worse Positions: Sitting, standing, walking, lying on back, lying on side L/R, or position doesn't matter

Associated Symptoms: Bruising, numbness, tingling, locking, swelling, other ______________________

Previous treatment for problem:

Dr. ____________________, ER/Clinic _____________, Other ______________, Date ___________

Diagnostic studies for this problem/facility where study was done: MRI/_________, X-Rays/ ________,

CT scan/ ___________________, NCV/EMG/ ________________, Other?____________________

Signature of Patient or Legal Guardian: __________________________ **Date** _____/_____/_____

Revised: 05/2016

Patient name____ Date: _____/_____/______

Review of systems: (PLEASE CIRCLE ALL THAT APPLY)

General: chills, fatigue, fever, other _________________, unexpected weight loss, weight gain, **NONE**

Neurological: Dizziness, numbness, other _______________, tingling or tremor, unsteady gait, **NONE**

Gastrointestinal: Abdominal pain, black stools, bloody stools, heartburn, other _____________, **NONE**

Respiratory: Chest tightness, cough, other ___________, pain breathing, shortness of breath, snoring, wheezing, **NONE**

Genitourinary: Blood in urine, flank pain, frequency, other ________, urgency, painful urination, **NONE**

Dermatologic: Abrasions, grayish skin, itching, other ________________, poor healing, skin redness, skin changes, laceration, **NONE**

Musculoskeletal: Feeling of heat, joint pain, joint stiffness, joint swelling, joint instability, other _________________, **NONE**

Endocrine: Abnormal blood glucose, cold intolerance, excessive thirst, frequency of urination, heat intolerance, other ________________, **NONE**

Hematologic: Bleeding tendency, bruising easily, other ______________________________, **NONE**

Mental status: Anxiety, depression, hallucinations, nervousness, other ___________________, **NONE**

Ophthalmologic: Blurred vision, corrective lenses, eye pain, other _____________________, redness, watering eyes, **NONE**

ENT: Difficulty swallowing, earache, headache, nosebleeds, other ___________, ringing in ears, **NONE**

OB/Gyn: Menopause, painful periods, pregnant, other ____________________, **NONE/not applicable**