| Injury Evaluation Primary Care Physician: Primary Care Physician | Name: | |
|--|--|---|
| Injury Evaluation Primary Care Physician: Primary Care Physician | DOB: | Ortho Cincy |
| Referring Physician: | Date: | |
| Referring Physician: | | Injury Evaluation |
| Name a favorite hobby: Describe how it happened Describe where you were: Personal Injury | Referring Physician: | |
| Describe how it happened Describe where you were: Personal Injury | | |
| Describe where you were: Personal Injury | | |
| Personal Injury | | |
| What makes it worse? On this diagram mark where your pain is: • The pain is: RARE INTERMITTENT CONSTANT • The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: Circle ALL that apply: • Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN OTHER When is your pain worse? Mornings Evenings Always about the same What is your pain scale today: • On pain 10-worst pain 12 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 Have you ever experienced any injury to or symptoms involving this body part in the past? yes no If so, please provide details: What test have you had regarding this injury? NONE X-rays MRI CT scan Bone scan EMG/NCV Ultrasound Labs Other: Have you had any treatment for this problem? NONE medication therapy splinting/brace injection surgery manipulation chiropractic treatment massage acupuncture pain specialist • Was any of your treatment effective? Explain: | ☐ Personal Injury ☐ Fall | ☐ Sports Injury ☐ Work related ☐ Chronic |
| What makes it worse? On this diagram mark where your pain is: For each, circle what BEST applies: • The pain is: RARE INTERMITTENT CONSTANT • The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: Circle ALL that apply: • Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN OTHER When is your pain worse? Mornings Evenings Always about the same What is your pain scale today: 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 O=no pain 10=worst pain O=worst pain O=w | The date the symptoms began: | |
| On this diagram mark where your pain is: For each, circle what BEST applies: The pain is: RARE INTERMITTENT CONSTANT The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: Circle ALL that apply: Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN OTHER When is your pain worse? Mornings Evenings Always about the same | What makes it better? | |
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| Have you ever experienced any injury to or symptoms involving this body part in the past? | What is your pain scale today: | 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 |
| If so, please provide details: What test have you had regarding this injury? | 0=no pain 10=worst pain | RIGHT LEFT |
| Ultrasound ☐ Labs ☐ Other: ☐ NONE ☐ medication ☐ therapy ☐ splinting/brace ☐ injection ☐ surgery ☐ manipulation ☐ chiropractic treatment ☐ massage ☐ acupuncture ☐ pain specialist ☐ other: • Was any of your treatment effective? Explain: | Have you ever experienced any i If so, please provide details: | jury to or symptoms involving this body part in the past? |
| □ surgery □ manipulation □ chiropractic treatment □ massage □ acupuncture □ pain specialist □ other: • Was any of your treatment effective? Explain: | | |
| Whore did you receive treatment? | surgery manipulation other: | ☐ chiropractic treatment ☐ massage ☐ acupuncture ☐ pain specialist |
| | . Whore did you receive the | |

Patient Signature: