Name:

DOB:

Date:

Injury Evaluation

Referring Physician: ____________________ Primary Care Physician: ____________________

Name a favorite hobby: ____________________

Describe how it happened ____________________

Describe where you were: ____________________

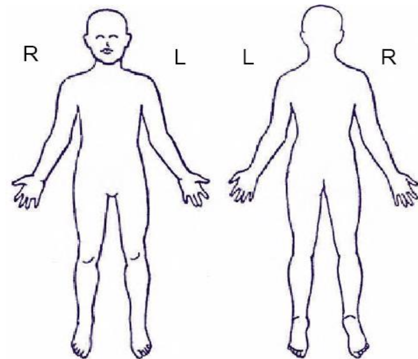
☐ Personal Injury ☐ Fall ☐ Sports Injury ☐ Work related ☐ Chronic
☐ Auto Accident-were you wearing a seatbelt? ☐ yes ☐ no

The date the symptoms began: ____________________

What makes it better? ____________________

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=no pain 10=worst pain	0 1 2 3 4 5 6 7 8 9 10 RIGHT	0 1 2 3 4 5 6 7 8 9 10 LEFT

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
☐ other: ____________________

- Was any of your treatment effective? Explain: ____________________

____

- Where did you receive treatment? ____________________

Patient Signature: ____________________

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