

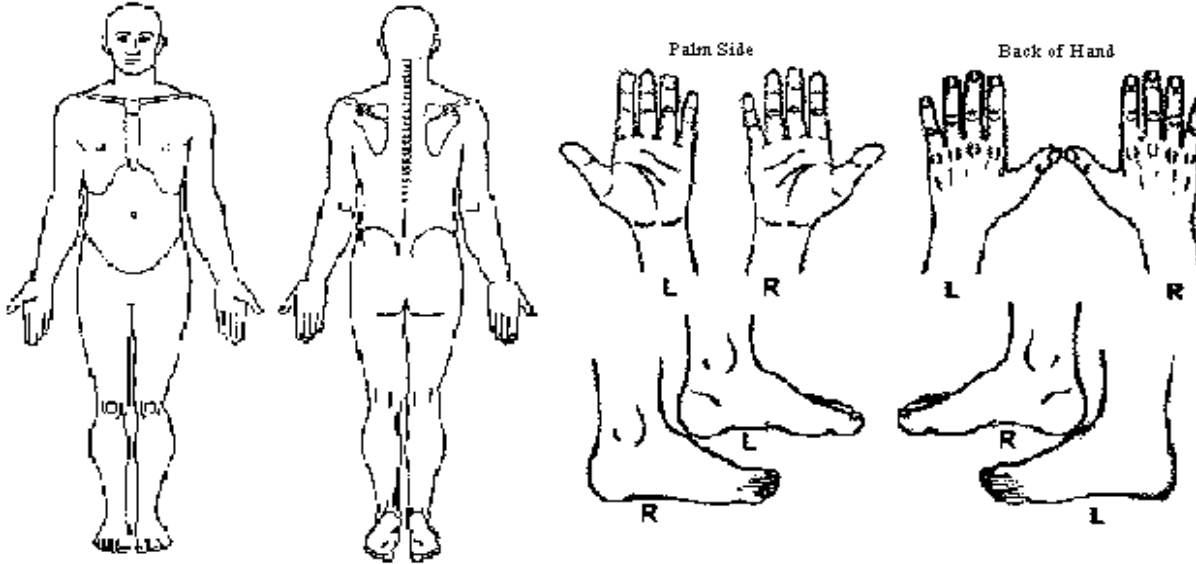
New Problem or Injury

Patient Name: _____ Date of Birth: _____

What is the reason for your visit/what is the chief complaint? _____

What caused the problem? _____

Please mark on the diagram where you are having the problem:



How long have you had this problem? _____ days weeks months years (circle one)

Please mark the symptoms that apply:

- ◇ Pain ◇ Swelling ◇ Bruising ◇ Tingling ◇ Numbness ◇ Laceration/Bleeding ◇ Unstable/Weak
- ◇ Locking ◇ Popping ◇ Grinding ◇ Catching ◇ Other: _____

What is the severity of the symptoms? (1-10 rating, 10 is the most severe): _____

Past Treatment for this problem:

- ◇ Emergency Room ◇ Primary Care Doctor ◇ Physical Therapy ◇ Occupational Therapy ◇ Surgery
- ◇ Icing ◇ Heat ◇ Brace or Sling ◇ Other: _____
- ◇ Medications: _____

What has helped reduce the symptoms?: _____

Patient/Guardian Signature: _____ Date: _____