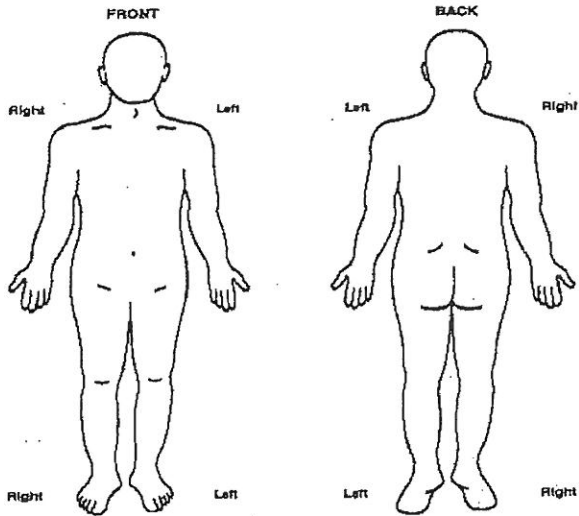


Mark the areas where you feel the above pain or sensation



CURRENT PROBLEM QUESTIONNAIRE

Patient Name: _____

DOB: _____ Date _____

Lt. ___ or Rt. ___ handed

What is your pain level? On a scale from 0-10

0 _____ 5 _____ 10

Did another doctor send you to this office for evaluation?

Yes No Dr. _____

- I am being seen for my: Right Left Bilateral (both)

Shoulder Arm Elbow Forearm Wrist Hand Finger Neck Hip Thigh Knee

Leg Ankle Foot Toe Back
- Symptoms radiate to my: Right Left Shoulder Arm Hand

Fingers Hip Thigh Leg Foot Toes
- Are your symptoms a result of an injury? Yes No Date of injury: _____

Is the injury worker's comp.? Yes No If yes, type of work: _____

Give an approximate time when your symptoms began (if no injury) : _____

Briefly describe the injury and/or development of your symptoms: _____

- Did you seek medical treatment prior to this visit? Yes No

If so, where: Emergency Room Urgent Care Physician's office Other

Name of Physician and/or facility who treated you: _____

What kind of treatment was given to you? Physical Therapy Injections

What medication was given?

Narcotic (vicodin) Anti-Inflammatory (Advil) Muscle Relaxers (soma) Steroids (prednisone)

Have you had any studies of the involved area within the past year?

X-rays MRI CT Scan other _____

Have you had surgery on this body part? Yes No Describe: _____
- Have you had symptoms or an injury to this area before? Yes No Describe _____
- Does the pain keep you up at night? Yes No
- How far can you walk (in miles or blocks)? _____

Patient/Representative Signature

Doctor's Signature

Returning Patient Medication Update

Medication	Dosage	How often do you take?

_____ **NONE**

Patient/Representative Signature

Doctor's Signature