NAME: ____ DOB: ________________________

EMERGENCY CONTACT: _____________________________ PHONE: ______________________

PRIMARY CARE PHYSICIAN: ____

HEIGHT: ______________ WEIGHT: _________________ ARE YOU A VETERAN? **YES** OR **NO**

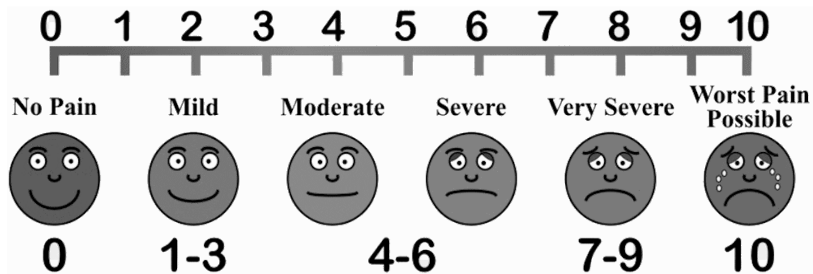
HISTORY OF PRESENT ILLNESS

WHAT **BODY PART** ARE YOU HERE FOR: **RIGHT** / **LEFT** / **BOTH**

☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGER(S) ☐ OTHER: ____________________

☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOE(S) ☐ BACK (**UPPER** / **MIDDLE** / **LOWER**)

RATE YOUR PAIN LEVEL:
(PLEASE CIRCLE A NUMBER)



ONSET **DATE** OF SYMPTOMS: _____/_____/______

WAS THIS AN INJURY? **YES** OR **NO** IF YES, **HOW?**____

DESCRIBE THE ONSET / INJURY: ____

☐ ACHE ☐ NUMBNESS ☐ PINS & NEEDLES ☐ BURNING

☐ STABBING ☐ RADIATING PAIN: **WHERE?** ___________________________ ☐ OTHER: _________________

WERE YOU SEEN IN A HOSPITAL OR ER? **YES** OR **NO** FACILITY: ___________________________________

WERE X-RAYS / MRI / TESTING DONE? **YES** OR **NO**. DID YOU BRING IMAGING TODAY? **YES** OR **NO**

INJURY COMPENSATION

WERE YOU ON THE JOB WHEN THIS INJURY OCCURRED? **YES** OR **NO**

HAVE YOU FILED A WORKERS COMPENSATION CLAIM? **YES** OR **NO**

LIABILITY CASE? **YES** OR **NO** ATTORNEYS NAME: ____

____ ______________________

PATIENT / PARENT CARE GIVER SIGNATURE **DATE**