



Date of Visit: _____

Patient Name: _____

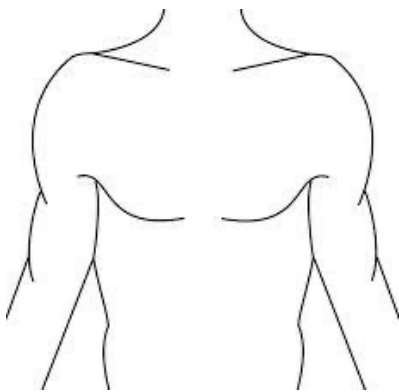
Patient DOB: _____

Chief Complaint (what you are seeing Dr Jones for): _____

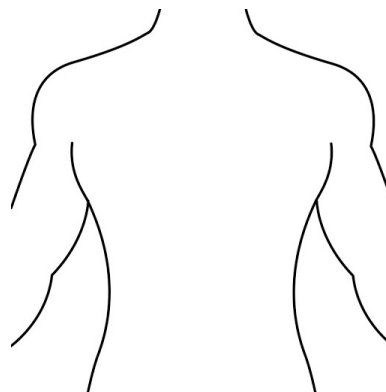
History

Where is your pain? _____

Front



Back



Describe your pain (sharp, dull, aching, radiating). _____

What activities/movements aggravate pain? _____

Is pain affecting your sleep? YES NO

How did this start (mechanism of injury)? _____

When did it start? _____

What treatments have you tried?

- Rest
- Ice
- Anti-inflammatories
- Physical Therapy
 - Where? _____
 - How long? _____
- Injections? _____

- How many? _____
- Given by whom - _____
- Prior Surgery? YES NO
 - What was done?

 - Who did the surgery?
