PATIENT EVALUATION **NAME** ______________________________

☐ Hand ☐ Wrist ☐ Elbow ☐ Ankle

Describe problem (pain, instability, weakness, etc.) ☐**Right** ☐**Left** ☐**Bilateral**

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Injury: How, when, what happened; did it swell immediately?
Date of Injury______________________________
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Have you had a similar problem in the past? If so, describe:
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What has been done so far?
☐ Surgery Dr.:______________________ Date of Surgery: ______________________
☐ X-Rays Last date taken: ______________
☐ Physical Therapy ______________________Relief felt: ☐None ☐Minimal ☐ Moderate ☐Significant
☐ Brace (Describe) ______________________ Relief felt: ☐None ☐Minimal ☐ Moderate ☐Significant
☐ Medication taken for this problem : ______________________________

PAIN:
During the last month, how frequently did you take medications for pain?
☐Never ☐Daily ☐Several times a week ☐About once a week ☐Less than once a week

How would you describe the relief from pain you received with pain medication?
☐Complete relief ☐Moderate relief ☐Very little relief ☐No relief

Is the pain medication you take prescription or over-the-counter pain medication?
☐Prescription ☐Over-the-counter ☐I take both prescription and over-the-counter medication

Type of pain: ☐Aching ☐Burning ☐Sharp ☐Dull
☐Radiating (Where?)______________________________
☐Constant ☐Intermittent ☐Present while lying in bed
☐Wake you from your sleep

On a scale from 0 to 10, mark your average level of pain discomfort during the last week, with 0 being none and 10 being unbearable.

None	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Unbearable
	1	2	3	4	5	6	7	8	9	10	

Pain made worse by: ☐Walking ☐Standing ☐Climbing ☐Going up stairs
☐Going down stairs ☐Squatting ☐Kneeling ☐Sitting with knee being (e.g. movies, airplane)
☐Running ☐Reaching ☐Pulling ☐Pushing ☐Grasping

Other:______________________________
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Pain relieved by: ______________________________