Name:

DOB:

OrthoCincy

Date:

Injury Evaluation

Referring Physician: _____ Primary Care Physician: _____

Name a favorite hobby: _____

Describe how it happened _____

Describe where you were: _____

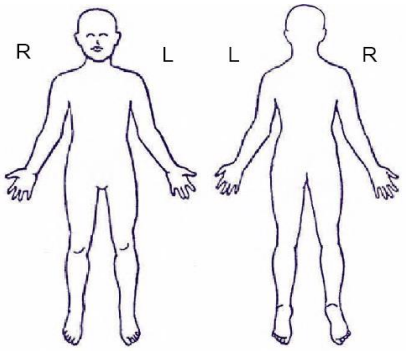
☐ Personal Injury ☐ Fall ☐ Sports Injury ☐ Work related ☐ Chronic
☐ Auto Accident-were you wearing a seatbelt? ☐ yes ☐ no

The date the symptoms began: _____

What makes it better? _____

What makes it worse? _____

On this diagram mark where your pain is:



For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: _____

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN OTHER _____

When is your pain worse? ☐ Mornings ☐ Evenings ☐ Always about the same

What is your pain scale today: 0=no pain 10=worst pain	0 1 2 3 4 5 6 7 8 9 10 RIGHT	0 1 2 3 4 5 6 7 8 9 10 LEFT

Have you ever experienced any injury to or symptoms involving this body part in the past? ☐ yes ☐ no
If so, please provide details: _____

What test have you had regarding this injury? ☐ **NONE** ☐ X-rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ EMG/NCV
☐ Ultrasound ☐ Labs ☐ Other: _____

Have you had any treatment for this problem? ☐ **NONE** ☐ medication ☐ therapy ☐ splinting/brace ☐ injection
☐ surgery ☐ manipulation ☐ chiropractic treatment ☐ massage ☐ acupuncture ☐ pain specialist
☐ other: _____

- Was any of your treatment effective? Explain: _____

_____

- Where did you receive treatment? _____

Patient Signature: _____

Provider Signature: _____ Date: _____

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