Mr Achan - Initial Clinic Evaluation Form

NAME: _____

Age? _____ **Today's Date?**_____

Date of Birth? _____

Occupation / job? _____

Did another doctor send you to us? Yes / No
If yes, please give name / address of that physician:

_____

_____

_____

Where is your problem? (please circle)

Shoulder Knee Elbow

Neck Back Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):

- ☐ Pain?
- ☐ Weakness?
- ☐ Instability / giving way / dislocation?
- ☐ Stiffness?
- ☐ Swelling?
- ☐ Other _____

How did you injure yourself?

- ☐ No injury – just started hurting
- ☐ Sports (which sport?)_____
- ☐ Motor vehicle accident
- ☐ Work / job –

Is there a workers comp claim? Yes / No

Sports level: none / recreational / college / professional

Date of injury?_____

How long have you had symptoms?
_____ Days _____ Mos. _____ Yrs.

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)?

_____

_____

How severe is the pain? ***(0 = none, 10 = severe pain)***

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired

☐ Normal job? ☐ Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any imaging studies?

X-rays	No / Yes	date:_____
MRI	No / Yes	date:_____
CAT scan	No / Yes	date:_____

Are you interested in surgery to correct your problem?
Please circle one: No / Yes / Unsure

Allergies to medication(s)? _____

Do any diseases run in your family? _____

<u>Medical History</u>: (please circle)

Do / did you have any heart problems?	No / Yes
Do / did you have ulcers / gastritis?	No / Yes
Do / did you have diabetes?	No / Yes
Do / did you have liver problems, hepatitis?	No / Yes
Do / did you have kidney disease?	No / Yes
Do / did you have blood clots?	No / Yes
Do / did you have cancer?	No / Yes
Do / did you smoke?	No / Yes

Other? (please use back of sheet as necessary)