REASON FOR VISIT

Patient Name: ____ Age: ____________

Current Physician: ____ Location: ____________________________

Height: ______________ Ft. ______________ In. Weight: ____________________ Lbs.

Reason for visit: ____ **Side**: right / left / both (circle)

Was there an injury? ________________ Is the injury related to work / auto / other (circle)

Problem start date/Date of injury: ____

Cause: ____

Have you tried any treatments for this problem (ex: medications, injections, surgery, therapy, etc.)? ____________________________

____

What makes the problem worse? ____

Movement limitations: ____

Does anything make the problem better? ____

Pain Scale: (circle, 0 is none and 10 is severe) **1 2 3 4 5 6 7 8 9 10**

The problem is: (circle) Improving / Unchanged / Worsening

Have you had any recent X-rays or other testing for this problem? What and where? ____________________________________

____

Current Pharmacy: ____________________________ Location: ____

I declare the above is correct to the best of my knowledge: ____

Patient/Parent/Guardian signature

For Physician Use Only:

General:

Mental Status:

General Appearance:

Orientation: person: place: time

Build/Nutrition: musc: In: ob: pet:

Integumentary: ecch: eryth: HI: II: lacer:

OpIn psor: rash:

Peripheral/Vasc: *Inspection* ery: gang: ulcer:

Palpation Hom: pulse: edema:

Neurologic:

Gait: Abnl. Asst. Dev:

Inspect/Palp: Tend: Swel: Eff: Crep:

Deformity/Malalign/Discrep: LLD: r<l: _______ l<r:_______

var: valg: ett: pPl: pCv: hv: Hgd:

Rom: flex ext: Hypext:

(A/P) Er: Ir: aBd:

PF: DF: In: Ev:

Fsup Fpro: TL:

Instability: ADr: Lach: Pvsh:

valgus: varus: TL:

Al: Pl: Sulc: Crank: MDI

Strength: flex: ext: ER: sup:

DF: PF: In: Ev: TL:

Functional Testing: McM: Thess: Thom: SLR:

pwrWE: pwrLFE: pwrWF:

Tin: Phal: Fink: GrT: FroS

Imp: ACca: blt: LO: ACT: O’b: