NEW PATIENT EVALUATION

Patient Name (print): ________________________ **Date of Birth:** ________________

Dominant hand: □ **R** □ **L** **Height:** ________ **Weight:** __________ □ **F** □ **M**

Who requested that you visit this office? □ **Doctor (name):** ____________ □ **Self** □ **Attorney**

1. Chief Complaint-Main reason for visit: □ Pain □ Numbness □ Weakness □ Other: ________________
2. Location- What body part is involved? (check the MAIN reason for your visit)

□ **Neck** □ **Back**	**Shoulder** □ **R** □ **L**	**Elbow** □ **R** □ **L**	**Hand** □ **R** □ **L**	**Pelvis** □ **R** □ **L**	**Knee** □ **R** □ **L**	**Foot** □ **R** □ **L**
Leg □ **R** □ **L**	**Arm** □ **R** □ **L**	**Wrist** □ **R** □ **L**	**Finger** □ **R** □ **L**	**Hip** □ **R** □ **L**	**Ankle** □ **R** □ **L**	**Toe** □ **R** □ **L**

3. Duration: How long has this problem been present? ____ Days ____ Weeks____ Months ____ Years
4. Check the **ONE** box below that best describes how your problem **started.** Then use the space to the right to answer the **ONE** question below the box you checked.
   - □ **No injury** (onset was □ Gradual or □ Sudden)
   - □ **Injury** (from accident or Sport NOT work or Auto)
   - □ **Injury at work** Date**:** ___________
     From a □ Lift □ Twist □ Bend □ Pull □ Reach
   - □ **Work Related** (But **NO** Injury)
     Date: ________How did your job cause this problem?
   - □ **Auto Accident** Date**:** ____________

Answer Comments:

____
____
____
____
____
____
____

Please check the box in each category that best describes your problem:

5. Average severity of pain: 0 1 2 3 4 5 6 7 8 9 10
6. Severity of pain at its worst: 0 1 2 3 4 5 6 7 8 9 10
7. Quality of pain: □Sharp □Dull □Stabbing □Throbbing □Aching □Burning □Other_________________
8. Timing of pain: □Constant □Comes and Goes(intermittent)
   a. Does pain wake you from sleep? □Yes □No
9. Do you have □ Swelling □ Bruising □ Numbness □ Tingling?
10. Since my problem started, it is: □Getting better □Getting worse □Unchanged
11. What makes your problem worse? □ Standing □ Walking □ Lifting □ Exercise □ Twisting □ Stairs □ Sitting □ Lying in bed □ Bending □ Squatting □ Kneeling
12. What makes it better? □ Rest □ Heat □ Ice □ Elevation □ Physical Therapy □ Massage □ Chiropractic adjustment □ Other_________________________
13. What medications have you taken for this condition? ______________________________________
14. Which treatment have you tried? □Injection □Brace □Therapy □Cane/crutch
15. What tests have you had? □X-rays □MRI □CAT scan □Bone scan □Nerve test (EMG)Patient

Patient Signature___________________________________ Date_____________________________