



Patient Name:	Today's Date:
DOB:	Age:

Office Use:

Where is your pain located?
Date of injury ~or~ When did your pain start / /
How did your pain problem start?
Have you had a motor vehicle accident or work injury with a suspected fracture? <input type="checkbox"/> Y <input type="checkbox"/> N

Please mark "YES" or "NO" for each of the following conditions:	
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had any prior surgery for this or similar type pain problem? If yes, when? / /
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have LEFT arm pain?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have RIGHT arm pain?
<input type="checkbox"/> Y <input type="checkbox"/> N	If yes to either, does the pain go below your elbow?

<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have TINGLING in your arms/ hands?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have NUMBNESS in your arms/ hands?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have WEAKNESS in your arms/ hands?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have NUMBNESS in your groin or buttock area?

<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any pain, numbness or weakness of your legs?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you lost control of your BLADDER function?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you lost control of your BOWEL function?

Office Use: