

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

Office Use:

Where is your pain located?
Which extremity hurts? (i.e. Left arm, Right arm, Left leg, Right Leg)
Date of injury ~or~ When did your pain start / /
How did your pain problem start?

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	Would you describe your pain as a BURNING pain?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your skin on this extremity SENSITIVE to light TOUCH? (such as stroking the skin with clothing or bed sheets)
<input type="checkbox"/> Y <input type="checkbox"/> N	Is your extremity PAINFUL to light PRESSURE?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does your extremity feel COLD at times?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does your extremity feel HOT at times?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does the skin on this extremity turn different colors?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there abnormal swelling or puffiness in this extremity?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this extremity SWEAT <u>more</u> than the other side?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this extremity SWEAT <u>less</u> than the other side?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there abnormal HAIR growth in this extremity?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there abnormal NAIL growth in the extremity?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this extremity have less RANGE of MOTION?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this extremity require a more focused attention to make it move?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this extremity feel like dead weight or like it is not part of your body?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there any NUMBNESS in this extremity?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is there any WEAKNESS in this extremity?
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any of the above symptoms in the opposite extremity?

Office Use: