NAME: _____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____ ARE YOU A VETERAN? **YES** OR **NO**

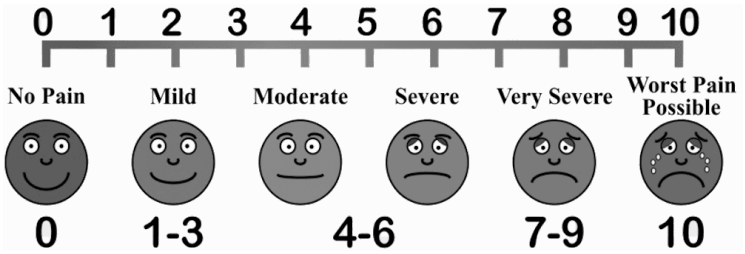
HISTORY OF PRESENT ILLNESS

WHAT **BODY PART** ARE YOU HERE FOR: **RIGHT** / **LEFT** / **BOTH**

☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGER(S) ☐ OTHER: _____

☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOE(S) ☐ BACK (**UPPER** / **MIDDLE** / **LOWER**)

RATE YOUR PAIN LEVEL:
(PLEASE CIRCLE A NUMBER)



ONSET **DATE** OF SYMPTOMS: ____/____/____ - WAS THIS AN INJURY? **YES** OR **NO** - IF YES, **HOW?** _____

DESCRIBE THE ONSET / INJURY: _____

☐ ACHE ☐ NUMBNESS ☐ PINS & NEEDLES ☐ BURNING

☐ STABBING ☐ RADIATING PAIN: **WHERE?** _____ ☐ OTHER: _____

WERE YOU SEEN IN A HOSPITAL OR ER? **YES** OR **NO** FACILITY: _____

WERE X-RAYS / MRI / TESTING DONE? **YES** OR **NO**. DID YOU BRING IMAGING TODAY? **YES** OR **NO**

INJURY COMPENSATION

WERE YOU ON THE JOB WHEN THIS INJURY OCCURRED? **YES** OR **NO**

HAVE YOU FILED A WORKERS COMPENSATION CLAIN? **YES** OR **NO**

LIABILITY CASE? **YES** OR **NO** ATTORNEYS NAME: _____

_____ _____

PATIENT / PARENT CARE GIVER SIGNATURE **DATE**