REASON FOR VISIT

What is the reason for your visit today? Please write down anything you want the doctor to know: _____

_____

_____

What caused your symptoms? _____ When? _____

Is this an injury from work or is this a Worker's Compensation claim? Yes No

How often are you feeling your symptoms? (Circle one) Constantly Frequently Occasionally Rarely

Describe your symptoms: (Circle all applicable)

Dull Sharp Throbbing Burning Deep Aching Tingling Stabbing Cramping Numbness Radiating Stiffness

How are your symptoms progressing? Getting worse Not changing Getting Better

Today how severe are the symptoms on a scale of 1-10? (Circle) 1 2 3 4 5 6 7 8 9 10

How much are your work or daily activities affected? Extremely Quite a bit Moderately Little bit None

Have you seen another provider for these symptoms? No Yes, explain: _____

What makes it worse? _____ What makes it better? _____

What concerns you most about this problem? _____

Have you had any MRIs or CT scans taken? Yes No

Name of your Primary Care Physician: _____

Mark your problem areas on the picture: