

_____ (affected area) RIGHT _____ LEFT _____ DATE: _____
Elbow Hand Ankle

Name: _____ Age _____ Height _____ Weight _____

Affected for: _____ days _____ months _____ years Injury Date _____ OR

Gradual Onset _____ Work Injury? Yes No Accident? Yes No Auto? Other?

How were you injured? _____ N/A

Upper extremity only: _____ Right or _____ Left Handed?

Pain: Rate your discomfortNone=0 | 2 3 4 5 6 7 8 9 10=Severe

Quality and Duration of the Pain: _____ Sharp _____ Dull _____ Burning _____ Throbbing

_____ Electric shocks _____ Constant _____ Intermittent (on and off)

In the past few days/weeks the pain has _____ increased _____ decreased _____ stayed the same

Where do your symptoms occur? _____ Front _____ Back

_____ Inside (medial) _____ Outside (lateral)

_____ Other (describe) _____

When do your symptoms occur? _____ At night _____ In the morning

_____ During exercise _____ After exercise _____ At work _____ After work

_____ Other (describe) _____

If these symptoms occur (Yes) please describe when or where. If not, indicate "No"

Stiffness No Yes _____

Numbness No Yes _____

Swelling No Yes _____

Weakness No Yes _____

Locking No Yes _____

Popping No Yes _____

Have you had any other treatment for this problem? (i.e. injections, glucosamine, etc.)
No Yes (describe) _____

What improves your symptoms? N/A Medication (list) _____
_____ Rest _____ Physical therapy _____ Heat _____ Ice _____ Brace/bandage _____ Exercise

Reviewed by: _____ Neal L. Rockowitz, M.D. rev 8/10