UPPER EXTREMITY INJURY - INTAKE FORM

Name: _____ **Age:** _____ **DOB:** _____ **Today's Date:** _____

Primary care physician: _____ **Referred by:** _____

Occupation: **Sports/Activities:**

Are you (please circle): RIGHT-HANDED LEFT-HANDED

Which area is bothering you? NECK SHOULDER ARM ELBOW FOREARM WRIST HAND

Which side are you here for today? RIGHT LEFT BOTH

When did your symptoms begin (specific date or in weeks/months/years**)?** _____

Was there a specific injury? Yes / No (If yes please describe): _____

_____

P**rior surgery/injury to this area?** Yes / No (Describe) _____

NATURE OF SYMPTOMS

Is your pain getting: BETTER WORSE SAME

Please rate your *average* level of pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Where is most of your pain? _____

Is your pain (or other symptoms): CONSTANT INTERMITTENT ASSOCIATED WITH ACTIVITY

Please list activities that are painful/difficult to perform: _____

_____

Is your pain: SHARP STABBING DULL ACHING

Do you have: a) Pain at night: Yes / No b) Pain with overhead activity: Yes / No

Please circle any of the following that you notice:

LOSS OF MOTION SWELLING WEAKNESS POPPING /CLICKING INSTABILITY

Do you have neck pain? Yes / No **Numbness or tingling into your hand or arm?** Yes / No

OTHER SYMPTOMS (warmth redness, fever, lacerations): _____

_____

PAST TREATMENT

Medications: _____ **Do they help?** Yes / No

Injections: Yes / No **How many?** _____ **Most recent** _____ **Did it help?** Yes / No

Physical Therapy: Yes / No **How long?** _____ **Did it help?** Yes / No

Other treatment: _____

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