

Patient Name _____	DOB: _____	AGE: _____
REASON FOR YOUR VISIT TODAY: _____		
DATE OF ORIGINAL INJURY OR ONSET? _____		
SINCE YOUR LAST VISIT IS YOUR CONDITION: () IMPROVED () WORSE () NO CHANGE		
IF IMPROVED WHAT HAS HELPED () Medication, () Physical Therapy, (Rest) <u>other:</u> _____		
WHAT ASSOCIATED SYMPTOMS DO YOU HAVE? (e.g., swelling, weakness, stiffness, giving way, numbness, dysesthesia, limp) _____		
SINCE YOUR LAST VISIT HAS THERE BEEN ANY CHANGE IN YOUR SOCIAL OR FAMILY HISTORY? () NONE		
SINCE YOUR LAST VISIT HAS THERE BEEN ANY CHANGES IN YOUR MEDICATION? NO YES		
IF YES PLEASE EXPLAIN. _____		
SINCE YOUR LAST VISIT HAVE YOU BEEN HOSPITALIZED? NO YES		
IF YES PLEASE EXPLAIN. _____		

FOR PHYSICIAN USE ONLY

PHYSICAL EXAMINATION

BODY AREA 1	BODY AREA 2
GENERALLY: Better No Change Worse	GENERALLY: Better No Change Worse
NEUROLOGICALLY: No-Change Positive Findings	NEUROLOGICALLY: No-Change Positive Findings
PAIN: Extremes Motion Full Restricted% _____	PAIN: Extremes Motion Full Restricted% _____
SPASM: Slight Moderate Severe	SPASM: Slight Moderate Severe
TENDERNESS: Slight Moderate Severe	TENDERNESS: Slight Moderate Severe
ADDITIONAL: _____	ADDITIONAL: _____

