Name:
DOB:
Chart:
Age:
Date:

BAYSIDE ORTHOPAEDIC
SPORTS MEDICINE & REHAB CENTER

CHIEF COMPLAINT

Please PRINT - All information must be completed.

Today's **CHIEF COMPLAINT:** _____ ☐ LEFT ☐ RIGHT ☐ BILATERAL
BODY PART

Date of Injury/Onset of Symptoms: _____ How did this injury occur? _____

Where did this injury occur? _____ Time of Pain: ☐ Night ☐ Day ☐ Constant ☐ Intermittent

Mark your current pain level below:

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible Pain

Associated Symptoms (select those that apply): ☐ Locking ☐ Popping ☐ Catching ☐ Swelling ☐ Giving Way
☐ Numbness ☐ Tingling ☐ Burning

Other comments we should know: _____

_____

Previous Treatment: ☐ Heat ☐ Ice ☐ Elevation ☐ Rest ☐ NSAIDs ☐ Brace ☐ Cast ☐ Splint
☐ Therapy ☐ Injection ☐ Surgery ☐ Other: _____

Treatment that helped: _____ Failed Treatment: _____

X-Ray/MRI/CT/EMG/NCV Other Imaging: _____ _____
WHEN WHERE

Previous Treating MD: _____ _____
NAME TREATMENT PLAN