

Name:
DOB:
Chart:
Age:
Date:



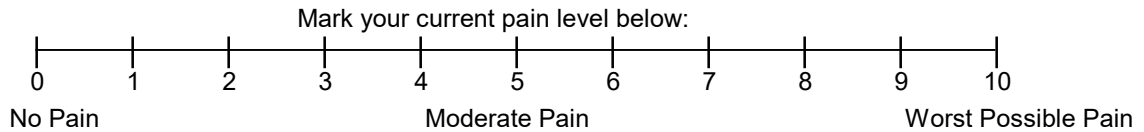
CHIEF COMPLAINT

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



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