Name: _____ Date: _____ MRN: _____

General Information

Age: _____ Height: _____ Weight: _____ Surgery Date: _____

Employer: _____ Position: _____

Do you have any special needs/concerns?

(i.e. vision, hearing, speech, language, translator, physical limitations, environmental concerns, etc)

❑ No ❑ Yes (Please list)_____

How did it start? _____

_____

What makes it worse? _____

_____

What makes it better? _____

_____

Is it better, worse or the same since it began? _____

_____

Circle the percentage of your daily activities you are able to do: 0% 25% 50% 75% 100%

List normal activities that you are unable to do or that are dificult because of this injury:

(include work, home and recreation)

_____

_____

List any sports or recreational activities you would like to get back to: _____

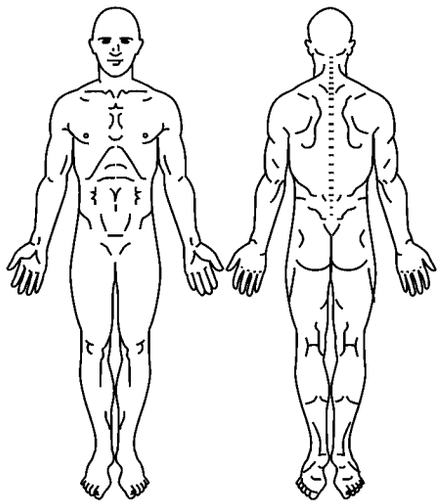
_____

Please describe your current symptoms using the following key.

/ / / = Stabbing a a a = Aching n n n = Numbness T T T = Tingling s s s = Sensitivity p p p = Other (Please describe)

Pain Intensity (please circle)

10 As bad as it could be
9 Excruciating
8
7 Severe
6
5 Moderate
4
3 Mild
2 Slight
1
0 No Pain



Percentage of the day you experience this level of pain? 0% 25% 50% 75% 100%

I only have pain when:_____