

Sports & Spinal Injury Clinic, LLC

Reason For Visit Form

NAME: _____ ID#: _____ DOB: _____ M / F DATE: _____

The reason for this visit is/Major complaint(s): 1. _____ 2. _____
 3. _____ 4. _____

Date each condition began? 1. _____ 2. _____ 3. _____ 4. _____

What caused your condition? 1. _____ 2. _____ 3. _____ 4. _____

When does it hurt? AM / PM # _____ Constant / Intermittent # _____ Daily / Weekly / Monthly # _____

Describe the quality/character of the pain of each complaint with its #: _____

Does it radiate to another part of your body? If so, where?: _____

Is condition getting: Worse? # _____ Better? # _____ Unchanged? # _____ Comes/goes? # _____

What helps your condition? 1. _____ 2. _____ 3. _____ 4. _____

What aggravates your condition? 1. _____ 2. _____ 3. _____ 4. _____

Associated Symptoms (Ex: headache, difficulty breathing, bowel/bladder dysfunction, etc.) _____

Level of physical activities now from 1 to 10? (1 = Sedentary & 10 = Active) _____ Level before? _____

Is this condition interfering with your: Work Sleep Daily routine? If any, how _____

Have you been treated by another Physician for **this** condition? Yes No If so, when and where? _____

Name of Hospital and/or Attending doctor? _____

Was he/she a: D.C. M.D. D.O. D.D.S. N.D. Other _____

How did you get there? Ambulance Private transportation Were X-rays taken? Yes No

Was medication prescribed? Yes No If so, what? _____

What's been done for this condition?: _____

To evaluate the effect that continuing work will have on your recovery please complete the following: (If applicable)

Have you been able to work since this injury? Yes No # of hours in normal work day? _____

Maximum weight you are required to lift? _____

Prior to injury were you physically capable of working on an equal basis with others your age? Yes No

While in recovery, is there any light duty work you could request? Yes No N/A

Please describe your job/work: _____

Please check any of the following activities that cause pain or discomfort.

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Sitting / Standing | <input type="checkbox"/> Bending Forward / Backward | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Pulling / Pushing / Reaching | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Running / Walking | <input type="checkbox"/> Lying on Back / Side / Stomach | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Lovemaking | <input type="checkbox"/> Turning Head / Back | <input type="checkbox"/> Working |

Please circle all **area(s)** of injury or discomfort and mark all areas with the appropriate symbols from below.

- NN = Numbness
- BB = Burning
- AA = Aching
- SS = Stabbing
- PP = Pins & Needles
- P = Pinching

