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 workday? _____

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.

❑ Sitting / Standing	❑ Bending Forward / Backward	❑ Twisting
❑ Kneeling	❑ Pulling / Pushing / Reaching	❑ Sports
❑ Running / Walking	❑ Lying on Back / Side / Stomach	❑ Lifting
❑ Lovemaking	❑ Turning Head / Back	❑ 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