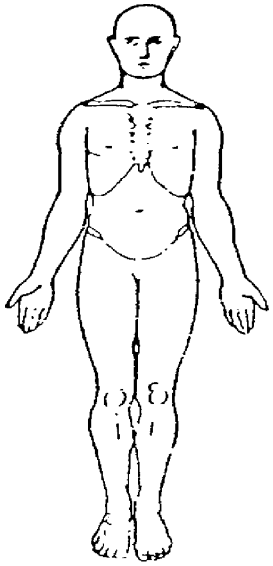
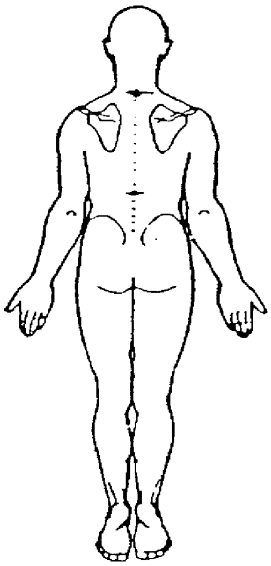
alpine orthopaedic SPECIALISTS

History Form

1. Please mark on the following diagram where your pain is, and use the key for pain types:





Key:

**** Tingling

----- Stabbing

⟶ Radiating

///// Aching

ΔΔΔ Burning

2. When did your current episode of pain begin? _____

3. What do you think caused your current pain? _____

_____

4. Have you had pain in this area previously? Please circle. Yes or No

5. If you answered yes, when and how did your original pain develop? _____

_____

6. How bad is your pain on a scale from 0 (no pain) to 10 (worst pain imaginable) when it is its worst? _____

When it is its best? _____ On average? _____

7. What makes your pain worse (types of activities and body postitions)? _____

_____

8. What helps improve your pain? _____

_____

9. Please list the names of medications you have taken to try and treat the pain. _____

_____

10. Please circle any of the following treatments you have tried. Physical therapy, chiropractics, massage, acupuncture, TENS unit, heat, ice, traction, braces, splints, orthotics.

11. If you have had surgery for this problem in the past, please list the dates and types of surgery. _____

_____

12. If you have tried other forms of treatment, please list them. _____

_____