LOWER EXTREMITY INJURY - INTAKE FORM

Name: _____ **Age:** _____ **DOB:** _____ **Today's Date:** _____

Primary care physician: _____ **Referred by:** _____

Occupation: **Sports/Activities:**

What area is bothering you? BACK HIP THIGH KNEE SHIN ANKLE FOOT

Which side are you here for today? RIGHT LEFT BOTH

When did your symptoms begin (specific date or in weeks/months/years**)?** _____

Was there a specific injury? Yes / No (If yes please describe): _____

_____

P**rior surgery/injury to this area?** Yes / No (Describe) _____

NATURE OF SYMPTOMS

Is your pain getting: BETTER WORSE SAME

Please rate your *average* level of pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Where is most of your pain? _____

Is your pain (or other symptoms): CONSTANT INTERMITTENT ASSOCIATED WITH ACTIVITY

Please list activities that are painful/difficult to perform: _____

_____

Is your pain: SHARP STABBING DULL ACHING

Do you have: a) Pain at night: Yes / No b) Pain with sitting: Yes / No c) Visible swelling: Yes / No

Please circle any of the following that you notice:

LOSS OF MOTION POPPING CLICKING INSTABILITY

Circle any activity that makes your pain worse:

SQUATTING RUNNING GOING UP STAIRS GOING DOWN STAIRS

Does your leg give out? Yes / No **Do you notice a painful click, pop, or catch?** Yes / No

OTHER SYMPTOMS? _____

PAST TREATMENT

Medications: _____ **Do they help?** Yes / No

Injections: Yes / No **How many?** _____ **Most recent** _____ **Did it help?** Yes / No

Physical Therapy: Yes / No **How long?** _____ **Did it help?** Yes / No

Other treatment: _____

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