ORTHOPAEDIC CENTER OF ILLINOIS

Christopher W. Maender, M.D.

Name:___________________________________

Referred by:______________________________

Hand Dominance (circle one): Left Right

Current Problem:
Date of injury: ___/___/____

Briefly describe your symptoms:____

____

____

What makes it better?____

What makes it worse?____

Is the pain better, worse, or the same as one month ago?_____________________________

Previous Treatments for this problem:

	Yes	No	Where?	When?
X-Rays	___	___		
MRI	___	___		
CT Scan	___	___		
EMG	___	___		

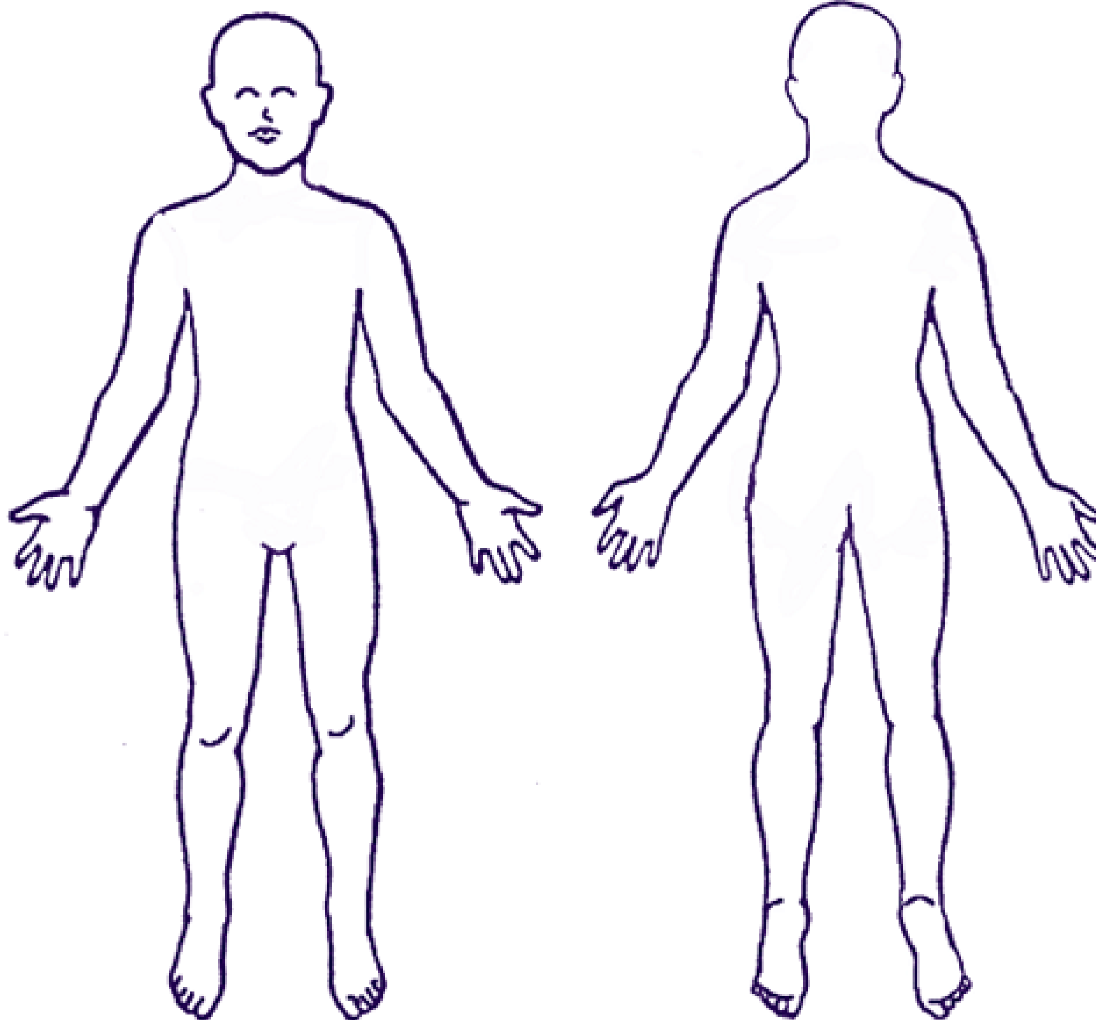
	Yes	No	Has it helped? Yes	Has it helped? No
Cast/Splint	___	___	___	___
Physical Therapy	___	___	___	___
Medications	___	___	___	___
Injections:	___	___	___	___
Surgery:	___	___	___	___

3136 Old Jacksonville Rd., Ste. 150, Springfield IL 62704
1600 W. Walnut St., Jacksonville, IL 62650
Toll Free (Springfield): 877-862-0624

Mark the area on the diagram below where you have:

Ache	Numbness	Pins & Needles	Stabbing	Burning	Shooting
AA	0000	xxxx	/ / / /	# # # #	y y y y

FRONT SIDE		BACK SIDE	
Right Side	Left Side	Left Side	Right Side



How bad is the pain on a 0-10 scale?

0 1 2 3 4 5 6 7 8 9 10

Mild Worse

I have reviewed the above information and hereby incorporate this into the medical record.

____________________________________M.D. Date_______________