

Clinical History Worksheet

Dr. Watson

Patient: _____ Account #: _____ Date: _____

Please write your orthopaedic problem here:

When did the pain start? _____

The problem primarily involves:	Neck	Middle Back	Lower Back
	Shoulder: R or L	Wrist: R or L	Hand: R or L
	Hip: R or L	Thigh: R or L	Knee: R or L
	Ankle: R or L	Foot: R or L	

What caused this problem to start? *Please circle*

Unknown Reason	
Motor Vehicle Accident	
Explain:	_____
Fall/Injury	
Explain:	_____
Other:	_____

How do you describe your pain?

Aching	Burning	Stabbing
Numbness	Tingling	Shooting
Other	_____	

How severe is the problem?

Mild	Moderate	Severe
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It is getting better or worse?

Better	Worse	Same
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What makes the problem better or worse?

Better:	_____

Worse:	_____

Have you recently been evaluated in an emergency room for this problem?

No	Yes—Date: _____
Place:	_____

Previous non-surgical treatments for the problem:

No previous treatment	Physical Therapy
Injections: How many _____	Brace
Chiropractic Manipulation	
Pain Medications:	
Name: _____	Dose: _____ How long: _____
Name: _____	Dose: _____ How long: _____
Name: _____	Dose: _____ How long: _____

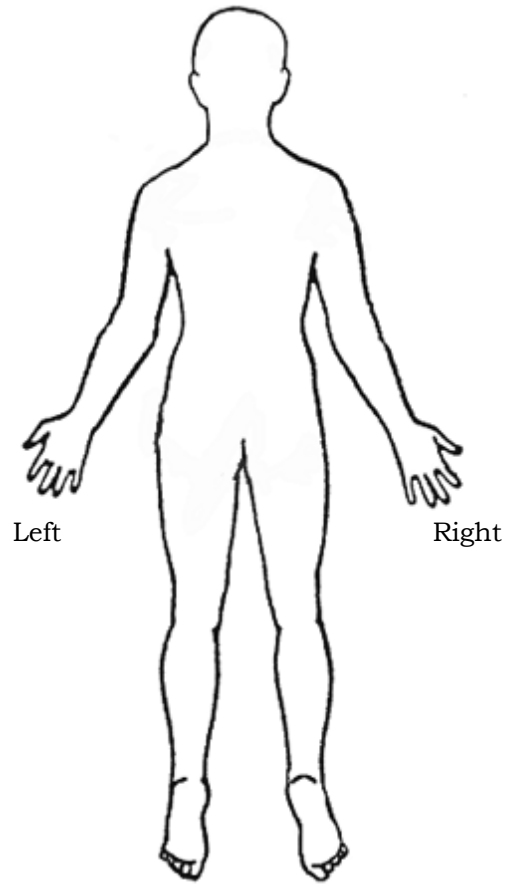
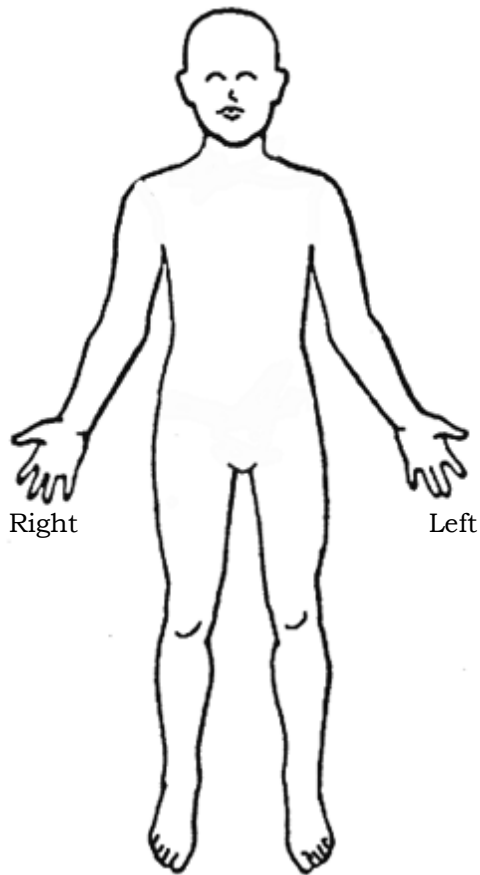
Physician(s) you have seen for this problem:

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Include all the affected areas.

ACHING ### NUMBNESS == PINS AND NEEDLES 0000

BURNING XXX STABBING ////



HOW BAD IS YOUR PAIN NOW?

Please mark with a large X on the body picture where the pain is the worst now.

Circle the number below that best shows how bad your pain is now.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain