

## New Injury Examination

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**What is the nature of your complaint:** \_\_\_\_\_

**When did it start?** \_\_\_\_\_ **Have you had this in the past?** Yes or No

**Have you seen any other doctors or therapists for this condition?** (circle all that applies)

Primary Care Physician Immediate Care Emergency Room Orthopedist Neurologist Pain Specialist Physical Therapist  
Chiropractic Physician Massage Therapist None

**What do you think caused this condition?** \_\_\_\_\_

**What activities or positions make it worse?** (circle all that apply)

Sitting Standing Laying on Back Laying on Stomach Laying on Side Walking Running Climbing Stairs Driving  
Reading Using Computer Bending Over Lifting Lifting Overhead Reaching Behind Back Using Hands None  
Other: \_\_\_\_\_

**What activities or positions make it better?** (circle all that apply)

Sitting Standing Laying on Back Laying on Stomach Laying on Side Walking Walking and Leaning on Cane or Shopping Cart  
Manipulation Exercises Ice Pack Heat Pack Stretching Massage Pain Creams Medication None  
Other: \_\_\_\_\_

**How would you describe your symptoms?** (circle all that apply)

Dull Ache Sharp Stabbing Shooting Numb Tingling Stiff  
Other: \_\_\_\_\_

**On a scale of 0 to 10, with 0 being the best and 10 being the worst, please rate the intensity of your symptoms?** (circle one)

0 1 2 3 4 5 6 7 8 9 10

**What percentage of the time do you have symptoms?** (circle one)

0-25% 25-50% 50-75% 75-100%

**Has there been any changes to your medical history since your last examination?** (circle one) Yes No

Name of Primary Care Physician: \_\_\_\_\_ City: \_\_\_\_\_

**Is it okay if we send a brief report to your Primary Care Physician about today's visit?** Yes or No