

Chief Complaint Form:			Date:	
Patient Name:	First		Last	Preferred Name
				_
Athlete: □	Sport:			_
Body part bein	ng seen for:			<u> </u>
Side of body:	(circle) Right	Left	Both	
How long have	e you had pain?: Days	Week	s Months	Years
Injury: □	Date of injury:			
If so, how did	it happen?			
Where is your	pain located? (e.g. front of kn	ee)		
Rate your <u>usua</u> NO PAIN	al pain: (circle) 0 1 2 3 4	5 6 7	8 9 10	THE WORST PAIN
Describe your	pain: (circle) Dull	Sharp	Stabbing	Aching
The pain over	time is described as: (circle)	Better	Worse	Same
What makes th	ne pain better:			
What makes th	ne pain worse:			
Numbness/ting	mptoms: (circle) gling Weakness Stiffness e describe:		11 0	Swelling Bruising
Previous evalu	ations: (Circle) PCP / Pedia	trician Ort	hopedic Surgeon	Other
Previous treatr Bracing Cast/splint	ment: (Circle) NSAIDs (e.g. Ibuprofen/Ad X-ray / CT / MRI	vil/Motrin)	Tylenol Narcoti	cs Injections Heat
Physical therap	py (if yes, please give dates, #	of weeks):		
Surgery (if yes	s, describe):			