ADVANCED ORTHOPEDICS & Joint Preservation

Assessment Form (Follow Up)

Doctor/PA_____

Patient's Name_____ Today's Date _____ /_____ / _____

Age: _____ Weight: _____ Height:_____ ❒ Right Handed ❒ Left Handed

Reason for evaluation:_____

Body parts: ❒ Right ❒ Left ❒B/L

❒ Hip ❒ Knee ❒Ankle ❒ Back ❒Shoulder ❒Elbow ❒Arm ❒hand ❒Other _____

Date Of Injury: _____/_____/_____

How long have *you* had the pain? 1 2 3 4 5 6 7 8 9 10 11 12
Hours / Days / Weeks / Months / Years

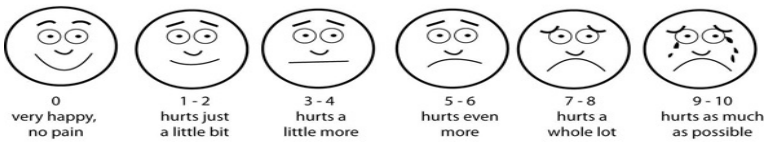
Was this a ☐ Job Related ☐ Car Accident ☐ Other Injury: _____

Did *you* receive medical attention? ☐ Yes ☐ No

Describe how *you* were injured:_____
_____

Are You in pain? ☐No ☐ Yes

Pain Assessment (circle one)



Frequency of pain: ❒Constant ❒ Intermittent ❒ Infrequent ❒ Rare ❒ Seldom

Quality of Pain: ❒Aching ❒ Cramping ❒ Dull ❒ Numbing ❒Pins & needle ❒ Sharp
❒ Shooting ❒ Stabbing ❒ Tingling ❒ Throbbing ☐ None

Radiation:_____

Severe Pain at its ***worse:***	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
Severe Pain at its ***best:***	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
Severe Pain ***right now:***	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10

What makes it worse? _____Relieving factors:_____

Any other associated Systems? _____

Any History of fall? ☐ **Yes** ☐ **No** History of Fibromyalgia? ☐ **Yes** ☐ **No**

Are you currently using any supporting devices? ☐ **Yes** ☐ **No**
☐ **cane** ☐ **crutches** ☐ **walker** ☐ **wheelchair** ☐ **Orthotic device**

Are you working? ☐ Full duty ☐ Light duty ☐ Not working due to this injury ☐Retired

☐ Not working If not working, when do you intend to return? _____

Are you taking any medication for the pain? ❒ yes ❒ no

If yes what medication?_____

Are you *currently* going to Physical therapy? ❒ yes ❒ no Do you feel it's helping? _____

How many times a week? _____ Doctor's Name:_____

Signature: _____ ***Today's date:*** _____/_____/_____