In case of an accident, injury, or sudden change in your condition . . .

Please give us the information listed below. Be sure to tell us what happened, where, when, and how the problem occurred. If you were hospitalized or received health care elsewhere, please give details.

Where is your major complaint? _____

Date of onset *(dd/mm/yyyy)*:_____

Onset was *(circle one):* sudden / gradual / associated with event

Please Explain: _____

How long have you had this condition? _____ minutes / hours / days

Has the problem been; constant / intermittent / occasional / cyclical

Indicate the present intensity of the pain by circling the appropriate number:

(mild) 1 2 3 4 5 6 7 8 9 10 (very intense)

Is the pain: dull / aching / burning / throbbing / sharp

Other: _____

What activities aggravate your condition: _____

What makes it feel better? _____

Does the pain limit your daily activities? Yes / No

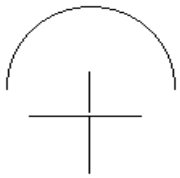
If yes, which activities are affected? _____

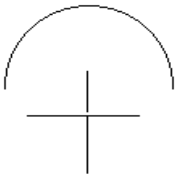
Print Name: _____

Signature: _____

Date: _____

Exam Notes

C/S 

L/S 

Bilateral Grip:_____

Bilateral Scales: _____

Supine Left Blood Pressure: _____

Supine Leg Strength:_____

Psoas Testing _____

Prone Leg Check _____

With C/S Rot _____

Sacral Leg Raise _____

Other:

_____

_____