

Manberry

TULSA BONE & JOINT ASSOCIATES INITIAL HISTORY

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI _____

Please complete both pages and feel free to write in your own responses.

1. What is your age? _____ What is your sex? _____
2. Which is your dominant arm: Right _____ Left _____ Ambidextrous _____
3. What body part are you being seen for today? _____
4. How long have you had the problem? _____
5. Is your complaint due to an injury? Yes _____ No _____
6. What date did the injury occur? _____

7. Which of the following traumas caused the condition? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Motor vehicle accident |
| <input type="checkbox"/> Direct blow | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Fall outstretched arm | <input type="checkbox"/> Other: _____ |

8. Have you ever had this condition before? Yes _____ No _____

9. Which of the following do you have? (Check as many of the following that apply)

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Locking |
| <input type="checkbox"/> Catching | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Popping | <input type="checkbox"/> Giving out/away |
| <input type="checkbox"/> Grinding | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Other: _____ |

10. The pain is (Check as many of the following that apply)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Activity related | <input type="checkbox"/> Worse in AM |
| <input type="checkbox"/> Worse in PM | |

11. Which of the following best describes the pain? (Check as many of the following that apply)

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Pinching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Sore | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Tender | <input type="checkbox"/> Numbness |

12. Which of the following movements cause the pain to be worse? (Check any of the following that apply)

- | | |
|---|--|
| <input type="checkbox"/> Reaching outward | <input type="checkbox"/> Reaching sideways |
| <input type="checkbox"/> Reaching behind backside | <input type="checkbox"/> Throwing |
| <input type="checkbox"/> Lying on involved side | <input type="checkbox"/> Stair climbing |
| <input type="checkbox"/> Running/walking | <input type="checkbox"/> Other: _____ |

13. Does the pain radiate? Yes No

14. Where does the pain radiate?

- | | |
|--|---|
| <input type="checkbox"/> Neck to shoulder | <input type="checkbox"/> Down the leg |
| <input type="checkbox"/> Shoulder to neck | <input type="checkbox"/> Into the thigh |
| <input type="checkbox"/> Shoulder down arm | <input type="checkbox"/> Other: _____ |

15. Have you previously had any of the following treatments for this condition?

- | | |
|--|---|
| <input type="checkbox"/> Previous fracture treatment | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Chiropractic |

16. Does the pain interfere with your daily activities? (Check as many of the following that apply)

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Minimal |
| <input type="checkbox"/> No | <input type="checkbox"/> Moderately |
| | <input type="checkbox"/> Significantly |

17. Are you now taking any medication for this condition? Yes No

18. What medications are you taking now for this condition?

- | | |
|--|---|
| <input type="checkbox"/> Pain pills | <input type="checkbox"/> Muscle relaxants |
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Over the counter |

19. Do you have a history of the following? (Check any of the following that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Bone/joint problems |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Circulation disorders |
| <input type="checkbox"/> Don't know | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Other: _____ | |

20. Do you smoke? Yes No If yes, _____ PPD for _____ years.

