ORTHOPEDIC ASSOCIATES of Northern California

Todays Date:_____

Hand/Wrist/Elbow

NAME_____ **REFERRED BY?**_____

Which side are we seeing you for today (please circle)? Right Left Both
Occupation:_____ Are you currently working: _____
Do you feel your injury is work related? Yes No
Is there an open work comp claim for this injury? Yes No
Is your claim in Litigation? Yes No

How was your Hand/Wrist/Elbow injured
(Include date, if any, and how long you have had a problem)?

_____
_____
_____

PAIN
Where in the Hand/Wrist/Elbow does it hurt:_____
Frequency of pain: Constant Intermittent
Pain Scale (circle one): 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe
Symptoms (please circle)
Pain at night Stiffness Numbness Weakness

What makes the pain worse? _____

What makes the pain better? _____

Swelling Yes No

Loss of Motion Yes No

Prior Hand/Wrist/Elbow Problems Yes No

Prior Hand/Wrist/Elbow Surgery Yes No

Treatment Received for current condition
Medications _____
Injections _____
Physical Therapy (How many sessions) _____
Surgery _____
Other Physicians _____
Chiropractic _____
Brace _____
Other _____