

Today's Date: _____

Physician Name: _____

Referring M.D.: _____

Name: _____ Age: _____

Occupation: _____

Which hand / wrist / elbow? Right _____ Left _____ Both _____

Describe injury (if any) and date of occurrence: _____

Location of pain (please be as specific as possible): _____

Pain Scale (circle one):

1 2 3 4 5 6 7 8 9 10
Least moderate severe

Pain Quality:

Sharp Dull Throbbing
 Aching Burning

Do you have pain at night? Yes ___ No ___

Do you have stiffness? Yes ___ No ___

Do you have numbness? Yes ___ No ___

Do you have weakness? Yes ___ No ___

Where? _____

Where? _____

Where? _____

What makes pain worse? _____

What makes pain better? _____

Treatments you have tried:

Physical Therapy Yes ___ No ___

Injections Yes ___ No ___

Surgery Yes ___ No ___

Brace Yes ___ No ___

Medications Yes ___ No ___

List: _____

Physician Signature: _____ Date: _____

HAND / WRIST / ELBOW