John Bursell, MD

Gustavo Garcia, MD

Daniel Harrah, MD

Meghan Lindquist, PA-C

Name: ______________________________ **Age:** _____ **Date of Birth:** ________________

Date of Visit: ________________ **Handedness:** *(Circle one)* **Right / Left / Ambidextrous**

Chief Complaint: (*Reason for visit*)

When and how did the problem start: (*Please provide dates and a description*)

Location of Problem: (*Body parts or areas affected)*

Symptoms:

☐Sharp ☐Dull ☐Aching ☐Throbbing

☐Other *(please describe)*____

Describe the Severity:

☐Mild ☐Moderate ☐Severe ☐Disabling

Duration of Symptoms:

☐Rarely ☐Intermittent ☐Frequently ☐Constantly

Timing of Symptoms: *(e.g After Exercise/At Night/ When Typing, etc.)*

Associated Symptoms:

☐Bruising ☐Numbness ☐Tingling ☐Swelling ☐Tenderness ☐Sensitivity to hot temperatures

☐discoloration ☐Sensitivity to cold temperatures ☐Other:____________________________

What Makes the Problem Better:

☐Rest ☐Heat ☐Cold ☐Medication ☐Elevation ☐Compression ☐Other:________________

Course of the Problem: ☐Worse ☐Better No ☐Change

What Makes the Problem Worse:

How Bad is the Pain Now? 0=No pain 10=Immense Pain	**Location**
No Pain 0-1-2-3-4-5-6-7-8-9-10	
No Pain 0-1-2-3-4-5-6-7-8-9-10	