

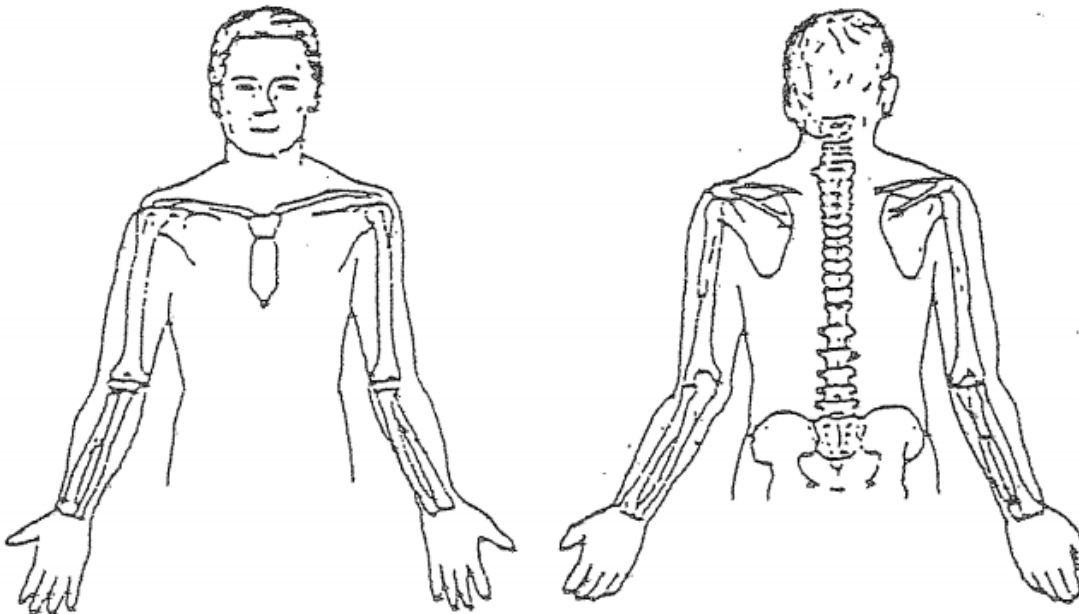
Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Hand Dominance R  L  Ambidextrous  Sex: M  F

Is your visit today due to an injury? Yes  No

If yes, what is the date of your injury? \_\_\_\_\_

Mark the area(s) where you are having pain in the illustration(s) below:



How bad is your pain at rest? (**mark** on line below)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
 No pain at all Pain as bad as it can be

How bad is your pain with activity? (**mark** on line below)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
 No pain at all Pain as bad as it can be

Do you feel joint instability? (as if it is slipping or coming out of place) Yes  No

If so, which joint? \_\_\_\_\_