TOSMG PRESENT COMPLAINT FORM

Name: _____ **Date of birth:** _____
Last **First** **MI**

Ethnicity: _____ **Language: ENGLISH Other:**_____
Has your insurance, phone number or address changed? Y / N _____
Day Time Phone Number: _____ Cell Phone Number: _____

Referring Physician: _____

Accident Location: _____

Have you missed work due to your concern? Y / N **First date missed** ____/____/____ to ____/____/____

Height:_____ Weight:_____

PRESENT COMPLAINT:

IS YOUR PRESENT COMPLAINT WORK RELATED? Y / N

Part of body: _____ Left / Right / Both

Onset: ____/____/____ gradual / sudden Duration: ____days/ weeks/ months/ year Pain Scale (1-10): ____

Status: improving /worse /stable /resolved /fluctuating Frequency: intermittent /constant /occasional /rare

Does your pain radiate? Y / N Where?_____ Quality: aching /burning /dull /sharp /throbbing

Context: no injury / injury / sports injury / motor vehicle accident / other: _____

Describe: _____

Trauma: Type: fall /running /direct blow /twisting /lifting /crush History of injury to area? Y / N Year: _____

Where: _____ Date: ___ /___ /___ or around: _____

Aggravated by: Nothing

bending / lifting / movement / walking / sitting / standing / pushing / pulling / stairs Other: _____

Relieved by: Nothing

splint / ice / heat / massage / therapy / elevation / exercise / stretching / medicines: _____

Associated symptoms: Nothing

bruising instability /tenderness /weakness /numbness /tingling /swelling /limping /locking /decreased mobility

Hand dominance: Left / Right / Ambidextrous

Patient's Signature: _____ Date: _____