EmergeOrtho Rehabilitation Center New Patient

Date: _____Date of Injury: _____Is this a work related injury? Yes____ No____

Medical Doctor: _____ Referring Physician _____

Chief Complaint: _____How did your pain start?_____

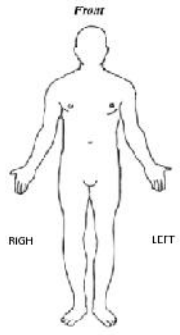
How long have you had this pain? _____ Have you ever had this type of pain before: Yes No

What activities make your pain worse? _____

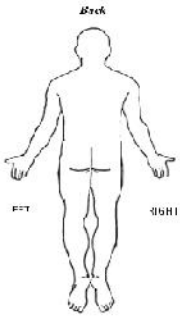
What makes your pain better? _____

Have you had x-rays relating to this condition? Yes___ No___

Shade the areas of the diagram below that correspond to your symptoms, Circle the words that best describe your symptoms, and draw arrows from the words to the areas they describe. Also circle the number, 0-10, that best rates your pain.



SHARP
DULL
ACHING
THROBBING
CRAMPING
PINS/NEEDLES
SHOOTING
STABBING
ELECTRIC
SHOCK
TINGLING
NUMB
WEAK
BURNING



No Pain-
Mild Pain-
Moderate Pain-

0 1 2 3 4 5 6 7 8 9 10

-None
-Annoying
-Uncomfortable
-Dreadful
-Agonizing

Height: _____ Weight: _____

PEG Scale: a three item scale assessing pain Intensity and Interference

1-What number best describes your pain on average since last visit

0 1 2 3 4 5 6 7 8 9 10

2-What number best describes how your pain has interfered with your enjoyment of life since last visit

0 1 2 3 4 5 6 7 8 9 10

1-What number best describes how pain has interfered with your general activity since last visit

0 1 2 3 4 5 6 7 8 9 10

TREATMENT	WHEN	WHERE	WAS IT HELPFUL
Physical Therapy/OT			
Chiropractic			
Massage			
Acupuncture			
TENS Unit			
Pain/Psychology/Biofeedback			
Epidural/Other Injections			
Surgery			
Spinal Cord Stimulator			