MOUNTAIN ORTHOPAEDICS

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Name: _____ Date: _____

What is the primary problem you'd like addressed? _____

_____

_____

How does this affect your life? _____

_____

_____

Which daily activities are you unable to do because of this problem? _____

_____

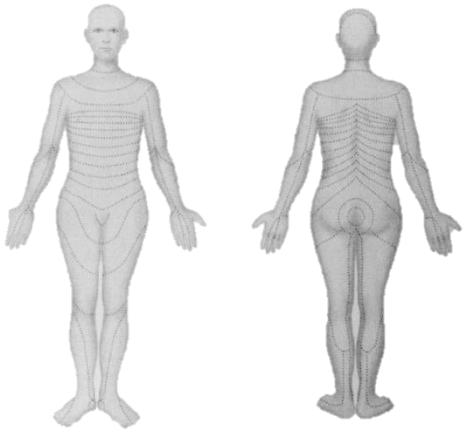
_____

Which daily activities are you still able to perform? _____

_____

Circle your lowest & highest pain levels: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Mark the location of your symptoms on the figures below. (Use the key below)



+ = pain
x = numbness
0 = weakness

How would you describe your overall health? _____

What major events are happening in your life? _____

_____

What is your goal in having this problem treated? _____

_____

Is there anything else you think I should know? _____

_____

_____

_____

_____

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