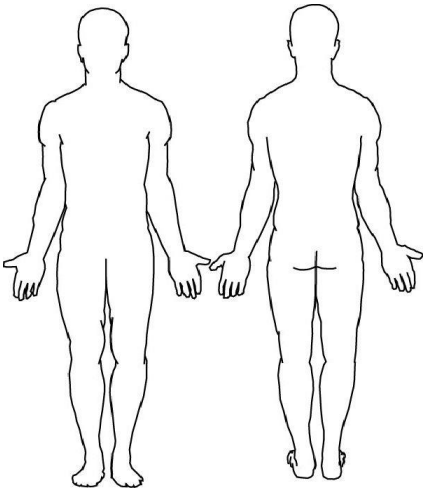
Name: _____ DOB: _____ Date: _____



DATE OF INJURY: _____

Cause of Injury: _____

_____

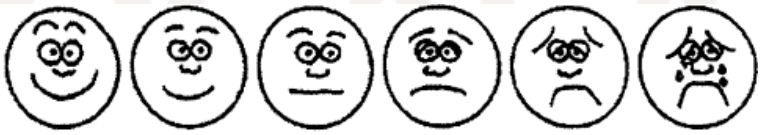
Shoe Size: _____

Complaint 1: _____

Complaint 2: _____

Complaint 3: _____

What is your overall health?



Pain Level (Circle)

Complaint 1: 0 1 2 3 4 5 6 7 8 9 10 Better? Same? Worse? (Left/Right/Both)
Complaint 2: 0 1 2 3 4 5 6 7 8 9 10 Better? Same? Worse? (Left/Right/Both)
Complaint 3: 0 1 2 3 4 5 6 7 8 9 10 Better? Same? Worse? (Left/Right/Both)

Pain Frequency (Circle One)

Complaint 1:	0-25	25-50	50-75	>75
Complaint 2:	0-25	25-50	50-75	>75
Complaint 3:	0-25	25-50	50-75	>75

Pain Quality (Circle)

Complaint 1: Sharp Ache Cramping Numbness Dull Throbbing Radiating Tingling Burning
Complaint 2: Sharp Ache Cramping Numbness Dull Throbbing Radiating Tingling Burning
Complaint 3: Sharp Ache Cramping Numbness Dull Throbbing Radiating Tingling Burning

Patient Signature: _____

Clinician Signature: _____

For Office Use Only:
ICD 10 Codes: _____ _____ _____ _____
CPT Codes: _____ _____ _____ _____
Addons: Ice pack Mag Back brace Cryoderm other: