BRIGHAM AND WOMEN'S HOSPITAL

INITIAL EVALUATION FORM

HARVARD MEDICAL SCHOOL
Teaching Affiliate

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____

Occupation/Job: _____

Email: _____

Will you allow a student to observe your visit? Y / N

Ht:___**ft**___**inches Wgt:**_____**lbs BMI:**_____
Did another Dr. send you to us? Yes / No
If yes, please give name/address of the physician:

_____

_____

_____

Where is your problem? (please circle)

Shoulder Elbow Knee Hip

Neck Back Other

Which sides(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):
☐ Pain?
☐ Weakness?
☐ Instability / giving way / dislocation?
☐ Stiffness?
☐ Swelling?
☐ Locking / Catching?
☐ Other _____

How would you rate your injured joint today as a % of normal (0-100%) with 100% being completely normal?_____%

How did you injure yourself?
☐ No injury–just started hurting
☐ Sports (which sport?)_____
☐ Motor vehicle accident
☐ Work / job–
Is there a worker's comp claim? Yes / No

Date of Injury? _____

How long have you had symptoms?

_____Days _____Months _____Years

Please briefly describe the injury:

_____

_____

_____

Previous Treatments (other than surgery?)
(medications, physical therapy, injections, bracing)

_____

_____

_____

Previous Surgery for this problem?

_____

_____

_____

How severe is the pain? (0=none, 10=severe)

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No

Does it awaken you from sleep? Yes / No

Are you currently working? Yes / No

☐ Normal job?

☐ Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations:

_____

Allergies to medication(s):_____

_____

Medical history: (please circle)

Do / did you have heart disease? No / Yes
Do / did you have ulcers / gastritis? No / Yes
Do / did you have diabetes? No / Yes
Do / did you have liver problems? No / Yes
Do / did you smoke? No / Yes

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