

Upper Extremity Evaluation

Name: _____ DOB: ____/____/____ Today's Date ____/____/____

Reason for visit: Shoulder Elbow Wrist Hand Other: _____

Side: Left Right Both Hand Dominance: Left Right Date of injury/Symptoms: ____/____/____

Have you had surgery on this body part? _____ If Yes, Procedure and Date _____

Is this a work related injury? Yes No Explain: _____

Is this a result of a motor vehicle accident? Yes No Explain: _____

Is this a sports related injury? Yes No Explain: _____

Onset: Sudden Gradual Duration: How long have you had this problem: # ____ Hours Days Weeks Months Years

Pattern: Constant Intermittent Persistent Course: Improving Worsening Recurrent Without Change

Radiation of Pain: None Neck Elbow Hand Fingers

Location:	Severity of Pain:	Characterized As:	Associated Features
<input type="checkbox"/> Front <input type="checkbox"/> Back	<input type="checkbox"/> None	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull	<input type="checkbox"/> Swelling <input type="checkbox"/> Loss of Motion
<input type="checkbox"/> Top	<input type="checkbox"/> Mild	<input type="checkbox"/> Aching <input type="checkbox"/> Throbbing	<input type="checkbox"/> Stiffness <input type="checkbox"/> Painful Motion
<input type="checkbox"/> Outside	<input type="checkbox"/> Mild to Moderate	<input type="checkbox"/> Cramping <input type="checkbox"/> Stabbing	<input type="checkbox"/> Popping <input type="checkbox"/> Dislocation
<input type="checkbox"/> Underarm	<input type="checkbox"/> Moderate	<input type="checkbox"/> Night Pain <input type="checkbox"/> Burning	<input type="checkbox"/> Grinding <input type="checkbox"/> Catching
<input type="checkbox"/> Shoulder Blade	<input type="checkbox"/> Moderate to Severe	<input type="checkbox"/> Numbness <input type="checkbox"/> Shooting	<input type="checkbox"/> Instability <input type="checkbox"/> Redness
<input type="checkbox"/> Entire Joint	<input type="checkbox"/> Severe	<input type="checkbox"/> Tightness <input type="checkbox"/> Like Band Around Arm	<input type="checkbox"/> Weakness <input type="checkbox"/> Warmth

Aggravated by:	Relieved by:	Have you had prior Physical therapy:	Use of Assisted devices:
<input type="checkbox"/> Nothing <input type="checkbox"/> Rest <input type="checkbox"/> Side Lying	<input type="checkbox"/> Nothing <input type="checkbox"/> Massage	<input type="checkbox"/> Yes <input type="checkbox"/> No When? _____ Where? _____	<input type="checkbox"/> None <input type="checkbox"/> Sling <input type="checkbox"/> Immobilizer
<input type="checkbox"/> Pushing <input type="checkbox"/> Any Movement	<input type="checkbox"/> Rest <input type="checkbox"/> Modified Activity		
<input type="checkbox"/> Pulling <input type="checkbox"/> Physical Activities	<input type="checkbox"/> Lying Down <input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Reaching <input type="checkbox"/> Sports Activities	<input type="checkbox"/> Ice <input type="checkbox"/> Medication		
<input type="checkbox"/> Lifting <input type="checkbox"/> Work Activities	<input type="checkbox"/> Heat <input type="checkbox"/> Bracing		
<input type="checkbox"/> Throwing <input type="checkbox"/> Overhead Activities	<input type="checkbox"/> Exercise <input type="checkbox"/> Cortisone Injections		

Previous Diagnostic Tests: X-ray MRI CT Scan Arthrogram Bonescan EMG/NCS

*Where was it taken?: _____

Review of Symptoms

Please check all that apply

General: <input type="checkbox"/> Feeling Well <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue Skin: <input type="checkbox"/> Bruising <input type="checkbox"/> Rash Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing	Cardiovascular: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema <input type="checkbox"/> Phlebitis Gastrointestinal: <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Constipation Psychiatric: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Dementia	Musculoskeletal: <input type="checkbox"/> Calf Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Leg Cramps Hematology: <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nose Bleeds	Neurological: <input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Unusual Sensation <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches Geniourinary: <input type="checkbox"/> Recurrent Urinary Infection <input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Prostate Cancer
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Patient Signature: _____ Date ____/____/____

Physician Signature: _____ Date ____/____/____