THE CENTER FOR ADVANCED SPORTS MEDICINE
KNEE AND SHOUDLER

ELBOW INTAKE FORM

Name:____ Date:____________

Occupation:____ Age:____________

Referred by:____

Primary Care Physician:____

CHIEF COMPLAINT:

- Is your problem in the: Right elbow Left elbow Both
- How long have you had this problem?__________________________________
- Is your problem getting: Worse Better Staying the same
- Was this the result of an injury? YES NO

  If yes, please describe how it happened:________________________________

  ____

- Is this a worker's compensation injury? YES NO

  If yes, please answer the following questions. If no, please advance to next heading

  1. Job title:____
  2. Date of injury:_____________________________________
  3. Are you: Off work Modified/light duty Full duty
  4. If you are not working, what date did you last work?______________

SYMPTOMS:

- If you are experiencing pain, where is it located? ______________________________
- Please rate the intensity of your pain/discomfort. (0 = no pain; 10 = severe pain)

  0 1 2 3 4 5 6 7 8 9 10

- Please describe your pain:

  off and on constant dull sharp

  throbbing tight burning tingling

- Is your pain worse at any particular time of the day?

  Upon waking Daytime Night

- What activities make your pain/discomfort worse? (Example: writing, picking up objects).
  ____

- Do you experience any of the following?

	Yes	No	If yes, please describe
Stiffness			______________________
Numbness			______________________
Swelling			______________________
Weakness			______________________
Instability			______________________
Other			______________________

PRIOR TREATMENT:

- Have you tried any of the modalities below? Symptoms relieved?

	Yes	No	Description	(Y/N)
○ Medication			Names:______________	_______
○ Physical therapy			Length of time:______________	_______
○ Injections			How many:______________	_______
○ Other			Describe:______________	_______

MEDICAL HISTORY:

- Do you have a current of past history of the following?

	Yes	No	Please describe all "yes" responses.
○ Heart problem			______________________
○ Lung problem			______________________
○ High blood pressure			______________________
○ Diabetes			______________________
○ Cancer			______________________
○ Stomach problems			______________________
○ Kidney problems			______________________
○ Liver problems			______________________
○ Seizures			______________________
○ Thyroid problems			______________________
○ Other			______________________

- Please list all medications you are currently taking with dosage and frequency:

____

____

____

- Do you have any allergies to medication? YES NO If yes, please list:

____

- Please list past surgeries and hospitalizations:

____

____

- Do you drink alcohol? YES NO If yes, how much per week?____________
- Do you smoke? YES NO If yes, how much per day?______________

  How long have you smoked?___________
- Do you use a special diet? YES NO If yes, describe:______________________
- Do you exercise? YES NO If yes, describe:______________________
- Sports/Hobbies:____
- How tall are you?_________________ How much do you weigh?________________