

Bedford Orthopedics

Where is your Pain or Problem? (Circle all involved)

Upper Extremity			Lower Extremity			Spine
[] Shoulder	[Right]	[Left]	[] Hip	[Right]	[Left]	[] Neck
[] Arm	[Right]	[Left]	[] Thigh	[Right]	[Left]	[] Back
[] Elbow	[Right]	[Left]	[] Knee	[Right]	[Left]	[] Pelvis
[] Forearm	[Right]	[Left]	[] Leg	[Right]	[Left]	
[] Wrist/Hand	[Right]	[Left]	[] Foot/Ankle	[Right]	[Left]	

When did this start? _____; Has this happened before? _____

Did this happen at work? _____

How did this condition begin?

What treatment has been done for this?

What surgeries have been done for this?

What tests have been done for this?

Please rate your pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

Insignificant pain ----- > Worst pain in my life!

What makes the pain worse?

What makes the pain better?

Please use BLUE or BLACK ink only to complete this form. Please print