General Information Age: Height: Position:	Name:		Date:	MRN:	
Age: Height: Position:	General Information	on			
Employer:			Weight:	Surgery Date:	
Do you have any special needs/concerns? (i.e. vision, hearing, speech, language, translator, physical limitations, environmental concerns, etc) No Yes (Please list) What makes it worse? What makes it better? Us it better, worse or the same since it began? Circle the percentage of your daily activities you are able to do: 0% 25% 50% 75% 100% List normal activities that you are unable to do or that are difficult because of this injury: (include work, home and recreation) List any sports or recreational activities you would like to get back to: Please describe your current symptoms using the following key. /// = Stabbing a a a = Aching n n n = Numbness TTT = Tingling s s s = Sensitivity p p p = Other (Please describe) 10 As bad as it could be percuciating 8 8 7 Severe 6 6 Moderate 4 3 Mild 2 Slight 1 No Pain Percentage of the day you experience this level of pain? 0% 25% 50% 75% 100%					
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