

Dr. Nickson's Initial History

Date: _____ Patient Name _____

Height _____ / _____ Weight _____

Did you bring x-rays/CT/MRI/? Y N

What body part is involved?

Ankle R L Foot R L Toe R L Knee R L

How long has this problem been present? _____ Days Weeks Months

Please check the box below which best describes today's problem:

The pain is: Constant Comes and goes (Intermittent)

Severity of pain Mild Moderate Severe Extremely Severe

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching
Burning Other: _____

Are there associated symptoms? Swelling Numbness Weakness

Since my problem started, it is: Getting Better Getting Worse Unchanged

Does your pain wake you from sleep? Yes No

Do you have mechanical symptoms? Locking Catching Buckling Giving way

What makes your symptoms worse? Activity Exercise Work
Other _____

Which makes you feel better: Rest Heat Ice Elevation Nothing
Other _____

What medications have you taken or have been prescribed for this problem? _____

Check which treatments you have tried:

Injection Y N Brace Y N Therapy Y N Cane/Crutch Y N