Extremity Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

LAST NAME

AGE    WEIGHT    DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHAT AREA IS AFFECTED?

☐ LEFT  ☐ RIGHT

ANY SWELLING OR MASS?

WHAT DO YOU THINK CAUSED THE PROBLEM?

ANY OTHER MEDICAL CONDITIONS?  ☐ YES  ☐ NO

IF YES, PLEASE EXPLAIN:

Please circle the portion of your body that is in pain.
DESCRIBE YOUR GENERAL HEALTH: