

ELBOW / FOREARM HISTORY FORM

Patient Name: _____ **Date:** _____

1. Who referred you for this problem? _____

2. Nature of your elbow/forearm problem. (be specific as you can) _____
 _____ Right or Left

3. How long have you had this problem? _____

4. Was there a specific injury? Yes / No. If yes:
 How did the injury occur? _____

When was the injury? _____

Where did it occur? Home Work Sports Auto Accident Other _____

5. Is the problem work related? Yes / No If yes, has an L & I claim been filed? Yes / No

Are you still working? Yes / No Light duty or Regular duty? Full time or Part time

If no, when did you last work? _____

6. Current Symptoms:

Pain? Yes / No Location _____

Severity: 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Circle what aggravates pain.

Elbow movements Pushing/Pulling Lifting Grasping Pinching Hand & Wrist movements

What relieves pain? _____

Associated Symptoms

Pain at night? Yes / No Numbness in the arm or hand? Yes / No Swelling? Yes / No

Locking sensation? Yes / No Catching or Grinding sensations? Yes / No

7. What treatment have you tried? _____

Ice? Yes / No Heat? Yes / No Tylenol? Yes / No

Anti-inflammatories? Yes / No Which ones? _____

Home Exercises? Yes / No Physical Therapy? Yes / No Sling? Yes / No

Brace? Yes / No Tennis Elbow strap? Yes / No Other? _____

8. Have you had x-rays? Yes / No Where? _____ When? _____

Other studies? Yes / No (CT scans / MRI) Where? _____ When? _____

9. What activities/ exercises do you regularly participate in? _____

Are you still able to participate? Yes / No