

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Appt: \_\_\_\_\_

A Registered Trade Name of Gem City Bone & Joint, P.C.

### Please fill out these forms completely

We know that filling out these forms can be difficult – but please complete them carefully. Your accurate responses will give us a better understanding of you and your health problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated.

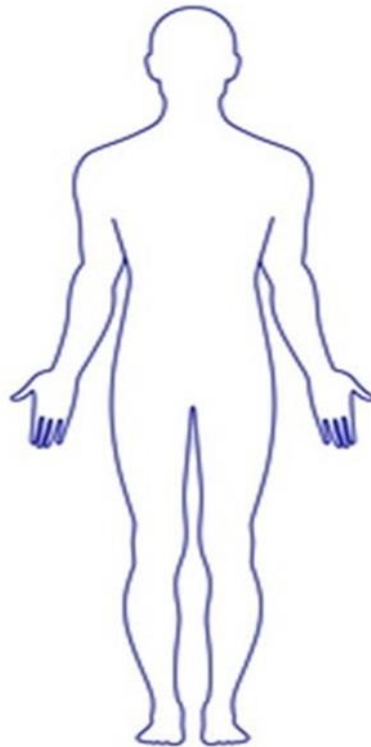
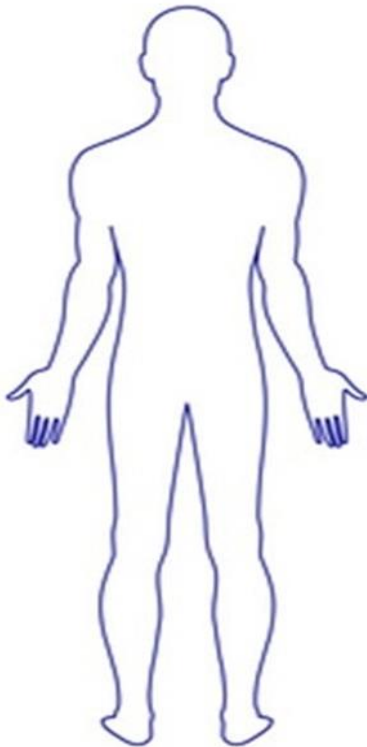
Thank you for helping us to know you better!

### PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to Right and Left sides.

FRONT

BACK



RIGHT

LEFT

LEFT

RIGHT

Ache

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Numbness

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Pins & Needles

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Burning

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Stabbing

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