FREEDOM
PROSTHETICS & ORTHOTICS

OFFICE VISIT RECORDS - Patient Problem Detail

Patient's Name: _____ **Date**: _____

Guardian/Parent Name: _____

What is the reason for your visit: _____

When was the onset of this problem: _____

On a scale of 1-10, with 10 being the highest, how would you rate your pain? _____

The onset of this problem was?:

☐ Gradual ☐ Sudden ☐ Without accident or injury

☐ After accident or injury

☐ Work-Related

How can the <u>current problem</u> be described?

☐ Aching ☐ Burning ☐ Constant ☐ Cramping ☐ Deep

☐ Dull ☐ Excruciating ☐ Intermittent ☐ Pressure

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing

Symptoms Improve with?

☐ Activity ☐ Heat ☐ Ice/Cold ☐ Medication ☐ Rest

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Additional symptoms you're experiencing:

☐ Bruising ☐ Chills ☐ Fatigue ☐ Fever ☐ Headaches

☐ Instability ☐ Limited Motion ☐ Numbness

☐ Popping/Snapping/Clicking ☐ Sleep Disturbance ☐ Stiffness

☐ Swelling ☐ Tenderness ☐ Tingling ☐ Weakness

Does the pain radiate to another body part: _____

What time of day are your symptoms the worst:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unchanged

What treatments have you tried for this problem (duration & outcome):

- ❏ Medications:_____
- ❏ Physical Therapy: _____
- ❏ Braces/Orthotics: _____
- ❏ Walking Aids (Crutches, Cane, Walker, Wheelchair):
  _____
- ❏ Injections (type): _____
- ❏ Weight Loss (Attempted): _____

How far can you walk:

☐ Around the house ☐ 1 Block ☐ ½ Mile ☐ 1 Mile ☐ More