

Willow Bend Sports & Spine Center Patient Intake Form

Name _____ Date _____

Date of Birth _____ Phone# _____

1. What is the “main” reason for your visit today? (Please limit each visit to ONE area of treatment) _____

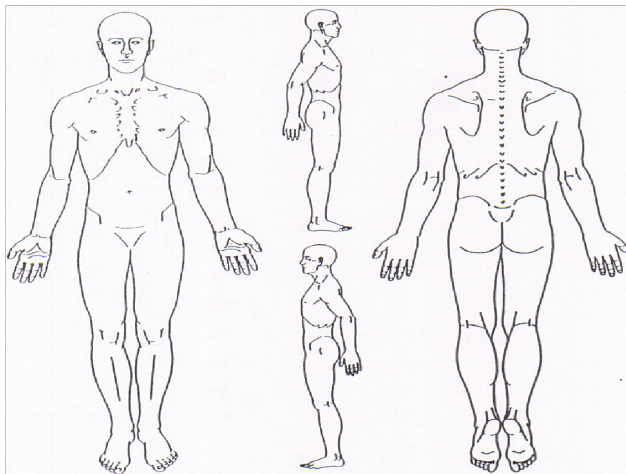
2. Please circle the severity of your main complaint

(None) 0 1 2 3 4 5 6 7 8 9 (Severe)

3. Please indicate your “overall” improvement of your condition since your initial visit.

No Change 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Using the diagram and symbols below, please indicate where you are experiencing your “main” complaint today



A=Aching B=Burning
C=Cramping D=Dull
N=Numbness S=Sharpness
P=Pins/Needles ST=Stabbing
T=Tightness

^^^=Shooting ///=Throbbing
+++=Tingling
O=Other: _____

5. Please describe ALL details concerning your “main” complaint
