

**Richard T. Dauphiné, MD**

**GENERAL EVALUATION FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Allergies to Medications?: \_\_\_\_\_

Problem Area(s) To Be Examined (right/left): \_\_\_\_\_

Date of Injury, or When Symptoms Began: \_\_\_\_\_ Work Related?: \_\_\_\_\_

How did the Injury / Problem occur? Please describe in detail: \_\_\_\_\_

**PRESENT SYMPTOMS: (Please note with a +, how often, and/or add a brief statement)**

\_\_\_ Pain (deep dull ache or sharp stabbing? where? when?) \_\_\_\_\_

\_\_\_ Swelling (when & amount) \_\_\_\_\_

**Knee / Ankle / Hip Symptoms**

- \_\_\_ night pain
- \_\_\_ stiffness
- \_\_\_ giving way
- \_\_\_ dislocation / reduction
- \_\_\_ popping (w/wo pain)
- \_\_\_ snapping
- \_\_\_ cracking
- \_\_\_ crunches
- \_\_\_ locking
- \_\_\_ catching
- \_\_\_ grinding feeling
- \_\_\_ fatigue
- \_\_\_ limp
- \_\_\_ back of knee
- \_\_\_ numbness, burning
- \_\_\_ other

**Shoulder / Neck / Elbow Symptoms**

- \_\_\_ tenderness
- \_\_\_ weakness
- \_\_\_ fatigue
- \_\_\_ loss of motion
- \_\_\_ instability
- \_\_\_ numbness / burning
- \_\_\_ stiffness "dead arm"
- \_\_\_ dislocation / reduction
- \_\_\_ noise (pain?)
- \_\_\_ locking
- \_\_\_ catching
- \_\_\_ grinding feeling
- \_\_\_ different color / temperature
- \_\_\_ headaches / dizziness
- \_\_\_ weather changes
- \_\_\_ other

**PRESENT FUNCTION: (Please note with a + things you are unable to do, also indicate time or distance if applicable.)**

- |                         |             |                      |                           |
|-------------------------|-------------|----------------------|---------------------------|
| ___ work                | ___ kneel   | ___ sports           | ___ sleep on injured side |
| ___ walk                | ___ squat   | ___ throwing         | ___ pull                  |
| ___ run                 | ___ driving | ___ reach overhead   | ___ lift                  |
| ___ twist               | ___ push    | ___ comb hair        | ___ climb stairs up/down  |
| ___ sit for a long time | ___ dress   | ___ use back pocket  | ___ grip normally         |
| ___ stand a long time   |             | ___ wash across body |                           |

**DATES AND NAMES OF PHYSICIANS HAVING TREATED YOU FOR THIS CONDITION BEFORE:**

**1. Doctor:** \_\_\_\_\_ **Approx. Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Xrays:** \_\_\_ Yes \_\_\_ No **Diagnostic Tests Performed:** \_\_\_ arthrogram \_\_\_ bone scan \_\_\_ MRI

**Treatment:** \_\_\_ rest \_\_\_ physical therapy \_\_\_ surgery \_\_\_ other \_\_\_\_\_

**Medication:** \_\_\_\_\_

**2. Doctor:** \_\_\_\_\_ **Approx. Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Xrays:** \_\_\_ Yes \_\_\_ No **Diagnostic Tests Performed:** \_\_\_ arthrogram \_\_\_ bone scan \_\_\_ MRI

**Treatment:** \_\_\_ rest \_\_\_ physical therapy \_\_\_ surgery \_\_\_ other \_\_\_\_\_

**Medication:** \_\_\_\_\_

**3. Doctor:** \_\_\_\_\_ **Approx. Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Xrays:** \_\_\_ Yes \_\_\_ No **Diagnostic Tests Performed:** \_\_\_ arthrogram \_\_\_ bone scan \_\_\_ MRI

**Treatment:** \_\_\_ rest \_\_\_ physical therapy \_\_\_ surgery \_\_\_ other \_\_\_\_\_

**Medication:** \_\_\_\_\_