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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: _____