Chart Note

Name: _____Date:_____

Age: _____PCP:(primary care physician):_____

CC: (chief complaint) _____

- Are you Right or Left handed? Right Left
- How long have you had this problem?_____
- How bad is your pain? Mild 1 2 3 4 5 6 7 8 9 10 Severe
- Did something happen to create your injury?

- Is there clicking or popping? Yes No
- Is there any numbness or tingling? Yes No
- Is there Swelling? Yes No
- Is there a history of injury to the area? Yes No
- Have you had this problem before? Yes No
- List everything you have tried for treatment