VALLEY ORTHOPAEDIC SPECIALISTS

Main Office:
2 Trap Falls Rd, Ste 404
Shelton, CT 06484
Phone: (203) 734-7900
Fax: (203) 513-3269

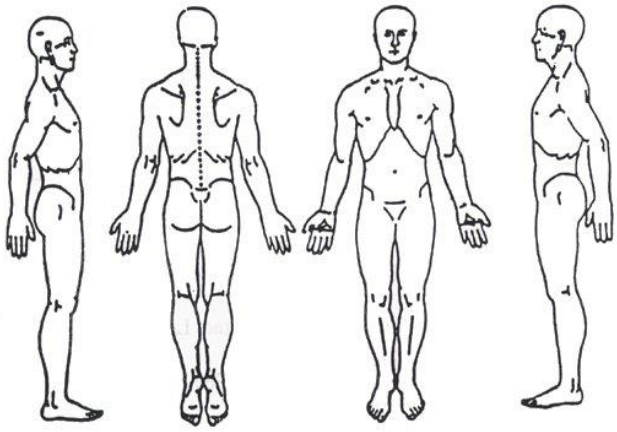
Oxford Office:
220 Main St, Ste 1F
Oxford, CT 06478
Phone: (203) 734-7900
Fax: (203) 463-8957

Fairfield Office:
1275 Post Rd, Ste 208
Fairfield, CT 06824
Phone: (203) 955-1202
Fax: (203) 955-1203

www.vosct.com

Name: _____ Date: _____ DOB: _____ Chart: _____

1. What is your **MAIN** complaint today? _____
2. On a scale of 1 to 10 (10 being the worst pain imaginable), what is your pain **TODAY**?
   Please Circle: 0 1 2 3 4 5 6 7 8 9 10
3. On the diagram below, place an **X** where pain is located and an **O** where numbness is located:



4. Is/are the treatments helping you function better? YES NO
   What is an activity that you are able to do because of the treatment you are receiving?_____

5. Your pain is present (Circle best answer): Constantly Frequently Intermittently Never

6. Describe your pain: (Circle all that apply):
   Burning Shooting Stabbing Tingling Throbbing Numbness
   Dull Pressure Ache Electric-like Other _____

7. What makes your pain worse? (Circle all that apply):
   Sitting Standing Walking Coughing/Sneezing Bowel Movements
   Lying down Other _____

8. What makes it better? (Circle all that apply):
   Rest Massage Acupuncture Physical Therapy Injections
   Chiropractic Medications

9. Has your sleep improved since your last visit? Yes No
10. Are you constipated? Yes No
11. Do you feel tired or sedated during that day? Yes No
12. Mood improved? Yes No
13. Do you smoke? Yes No
14. Has your activity increased since last visit? Yes No
15. Are you working? Yes No
16. LIST YOUR CURRENT MEDICATIONS: _____

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