



CINCINNATI BONE & JOINT INSTITUTE

Chief Complaint Form:

Date: _____

Patient Name: _____
First MI Last Preferred Name

Age: ____ DOB: _____ Occupation: _____ Employer: _____

Referring Physician: _____

Primary Care Physician: _____

Body part being seen for: _____

Side of Body: (circle) **Right Left Both**

Date Symptoms Began: _____

Was there an injury? (circle) **Yes No** Worker's Comp? (circle) **Yes No**

If so, how did it happen:

Current Symptoms: _____

If there is pain, where is it located? _____

Are your symptoms: (circle) **Improving Worsening Stable**

Are your symptoms: (circle) **Mild Mild/Mod. Moderate Mod./Severe Severe**

What activities or body positions make your symptoms worse?
(examples: walking, running, reaching overhead)

Have you had prior treatment? (examples: injections, surgery, physical therapy)
