Please complete and hand to the receptionist when you check in

Name: _____ Date: _____

D.O.B.: _____

1. Do you currently take NSAIDS? Yes or No (Circle or Select)
   (i.e. Aspirin, Ibuprofen, Advil, Aleve)

2. Have you tried Physical Therapy? Yes or No (Circle or Select)

   Start Date: _____ End Date: _____

   If yes, how many weeks/sessions? _____

3. Have you had injections? Yes or No (Circle or Select)

   a. If yes, how many and by whom? _____

4. What is your pain level out of 10? (10 being the worst)

   At worst _____, At rest _____ **(i.e., sitting, laying down, sleeping)**

5. Does the pain interfere with activities of daily living? Yes or No (Circle or Select)
   (i.e. walking, bending, weight bearing, or going up/down stairs)

6. Please circle one: current smoker former smoker never smoked (Circle or Select)

7. How many times in the past **YEAR** have you had **FIVE (males)** or
   FOUR (females and adults over 65) or more drinks in a **day**? _____

8. Any falls in the **past year**? Yes or No (Circle or Select)

   If yes, how many? _____ **Were you injuried**? Yes or No
   (Circle or Select)

9. Do you use crutches, cane or a walker to ambulate? Yes or No (Circle or Select)

10. Do you need to clutch onto furniture when ambulating for support? Yes or No (Circle or Select)

11. Who is your decision maker if unable to indicate wishes about future life sustaining medical treatment?

Name: _____ Relationship: _____

Contact information: _____

12. Do you have children? Yes or No (Circle or Select)

   If yes, how many? _____