

Name _____ DOB ____/____/____

What is the reason for today’s visit? (Please circle one)

Shoulder Elbow Hip Knee Other: _____

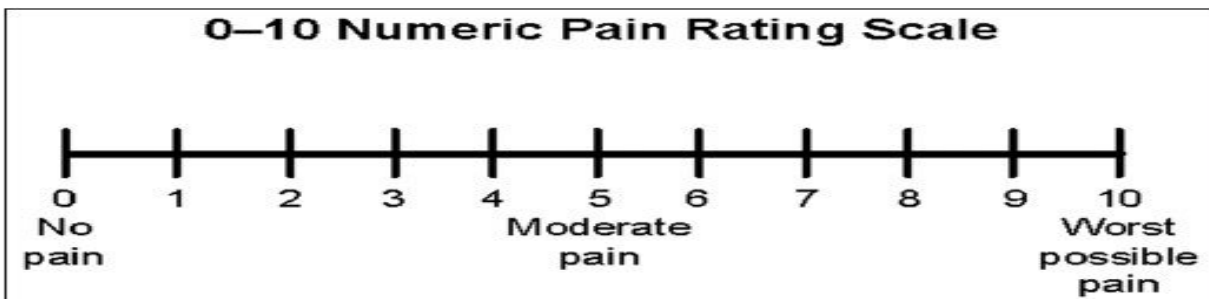
Affected side? Right () Left ()

Are you having pain today? Y () N ()

Has the pain improved since your last visit? Y () N ()

Please list any pain medication you are currently taking (Tylenol, Advil, codeine, etc.):

PLEASE CIRCLE THE LEVEL OF PAIN YOU ARE HAVING ON SCALE BELOW



UCLA Activity Score: Check one box that best describes your current activity level

- Wholly inactive, dependent on others, and cannot leave residence
- Mostly inactive or restricted to minimum activities of daily living
- Sometimes participates in mild activities, such as walking, limited housework, and limited shopping
- Regularly participates in mild activities
- Sometimes participates in moderate activities, such as swimming, or could do unlimited housework/shopping
- Regularly participates in moderate activities
- Regularly participates in active activities, such as bicycling
- Regularly participates in active activities, such as golf or bowling
- Regularly participates in active activities, such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, etc.
- Regularly participates in impact sports

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