

INJURY EVALUATION FORM

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Name _____ Age _____ Date _____

Involved body part _____ ☐ Right ☐ Left ☐ Both - ☐ Right worse ☐ Left worse

When did your problem start? _____ Was there an injury? ☐ Yes ☐ No

Describe what happened (i.e. got hit, twisted skiing, over time)

If injured, did you feel/hear a pop? ☐ Yes ☐ No

Did it swell? ☐ Yes ☐ No

When did it swell? ☐ Immediately ☐ Several Hours ☐ Next Day

Does it swell now? ☐ Yes ☐ No

If not injured, what activity do you think caused/contributed to the problem? _____

Do you have? ☐ locking ☐ clicking ☐ catching ☐ looseness/instability ☐ stiffness/loss of motion

☐ weakness ☐ sharp pain ☐ aching

Pain is located on? ☐ Front ☐ Back ☐ Inside (toward other side) ☐ Outside (away from other side)

What makes pain worse? ☐ twisting ☐ running ☐ up stairs ☐ down stairs ☐ kneeling ☐ squatting
☐ standing after being seated ☐ sleeping (pain awakens you)

What makes pain better? ☐ ice ☐ rest ☐ medication ☐ brace ☐ orthotics ☐ injections

How severe is the pain on average? (none) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

Medications taken for this ☐ Ibuprofen/Advil ☐ Naproxen/Aleve ☐ Other _____

Injections? ☐ Cortisone ☐ PRP ☐ Joint Lubricant date(s) _____

Percent improvement with injection(s) _____

Previous treatment for this problem: ☐ physical therapy ☐ brace ☐ orthotics ☐ surgery

Previous Surgery

Date

Surgeon

Previous injuries to this body part/date(s) _____

Have you had ☐ X-ray ☐ MRI ☐ Other test _____ for this condition

Sports/recreational activities _____

Level of sport ☐ High School ☐ College ☐ Professional ☐ Other _____

Occupation _____

Current School and Grade Level _____

Goals after treatment for this problem _____