

Please fill out only the form(s) for the body area(s) that were injured. You can type into this form on a computer or phone, save it, and email it to info@mlenj.com before your appointment, or print it and bring it with you. Please also bring any X-ray, MRI or CT films or discs you have.

Full name**Date of birth****Today's date**

Your injury

Which side was injured?☐ Left ☐ Right**Which area was injured? (check all that apply)**☐ Hip ☐ Thigh ☐ Knee ☐ Lower leg ☐ Ankle ☐ Foot ☐ Toes**When did the injury happen?****How did the injury happen?****Did you have problems with this body part before the injury?**☐ Yes ☐ No

Treatment and work

Which treatments have you had for this injury? (check all that apply)☐ Surgery ☐ Injections ☐ Physical therapy**Are you working now?**☐ Yes ☐ No**What is your job?**

Pain

Do you have pain?☐ Yes ☐ No**Do you take pain medication? If so, please list it:****Pain now (0 = no pain, 10 = worst pain imaginable)**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
0 = No pain 10 = Worst pain

Pain at its worst (0 = no pain, 10 = worst pain imaginable)☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10**Where is the pain? (check all that apply)**☐ Hip ☐ Thigh ☐ Knee ☐ Lower leg ☐ Ankle ☐ Foot ☐ Toes**What is the pain like? (check all that apply)**☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Stinging

Other:

How often do you have pain?☐ Sometimes ☐ All the time ☐ Never**Do you have numbness, tingling or other unusual feelings in your legs or feet?**☐ Yes ☐ No**If yes, please explain:**

Activities

Which activities are difficult for you now? (check all that apply)**At work**☐ Bending ☐ Lifting ☐ Carrying objects ☐ Using a computer ☐ Using tools**At home**☐ Sweeping floors ☐ Vacuuming ☐ Going up or down stairs ☐ Scrubbing pots or pans
☐ Mowing the lawn ☐ Gardening ☐ Doing repairs ☐ Climbing ladders**Leisure**☐ Riding a bicycle ☐ Playing sports ☐ Playing with children ☐ Picking up children
☐ Walking the dog ☐ Walking for leisure ☐ Jogging ☐ Working out at a gym ☐ Lifting weights
☐ Dancing ☐ Travel**Daily activities**☐ Driving ☐ Getting dressed ☐ Sleeping ☐ Kneeling ☐ Walking ☐ Sexual activity**Any other activities that are difficult for you:**