Chan Soon-Shiong Medical Center at Windber

Orthopedic Walk-In Clinic

SYMPTOM FORM

Patient Name:	**Today's Date:**
Reason for Visit Today:	
Any injury? □ Y or □ N	**If yes, how did injury occur:**
When did injury occur or pain begin?	
Location of pain:	
Level of pain: (no pain) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (worst pain imaginable)	
Describing Factors: □ Sharp □ Stabbing □ Aching □ Throbbing □ Dull □ Cramp	
Worsening Factors: □ Weight Bearing (standing on it) □ Activity □ Bending □ Lifting	
Additional Factors:	
What have you taken or done so far for pain?	
List any medications or treatments, such as physical therapy, chiropractor, injections, or surgery:	

Please check any symptoms you have had in the past week.			
□ Fever	□ Numbness	□ Blurry Vision	□ Vomiting
□ Chills	□ Tingling	□ Shortness of Breath	□ Change in Bowel or Bladder Habits
□ Malaise	□ Swelling	□ Cough	□ Skin Rash
□ Headache	□ Popping	□ Heart Palpitations	□ Open Wound
□ Dizziness	□ Clicking	□ Nausea	□ Other: