RapidSound, Inc / Green Valley Imaging
450 W Continental Rd
Green Valley, AZ 85622
520.625.7670

EXTREMITY EVALUATION FORM

Name: _____
Last First Middle

DOB: _____/_____/_____ Date: _____/_____/_____

1. What was your chief complaint when you visited your doctor? _____

_____

2. What do you think caused the problem? _____
3. What does your doctor think is causing your pain? _____
4. Describe your pain (i.e. burning, stabbing, sharp): _____

   Does anything make it better? _____ Worse? _____

5. Do you have any weakness? _____ Where? _____
6. Have you had surgery on the area of concern? _____ When? _____

   Facility? _____ What was done? _____

7. Have you ever broken any bones in the area of concern? _____

   Have you ever dislocated anything in the area of concern? _____

8. Do you have any arthritis in any of your joints? _____
9. Do you have any history of cancer? _____
10. Do you have any other medical conditions? _____
11. Describe your general health: _____

_____