CHEST EVALUATION

Last Name:	First:	Date:

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What do you think is wrong?

   _____

   _____

2. Describe your symptoms:

   _____

   _____

3. What makes it better?

   _____

   _____

4. What makes it worse?

   _____

   _____

5. Do you have areas of weakness? Yes or No (Circle one)

6. Weakness where?

   _____

   _____

7. Any surgery/arthroscopy on the scan area? Yes or No (Circle one)

8. Surgery/Arthroscopy when?

   _____

   _____

9. What was done?

   _____

   _____

10. Do you have arthritis in any of your joints? Yes or No (Circle one)

11. List Joints:

    _____

    _____

12. Are you currently taking any medications? Yes or No (Circle one)

13. List medications:

    _____

    _____

14. Do you have any other medical conditions? Yes or No (Circle one)

15. List conditions:

    _____

    _____

16. List athletic activities that may have contributed to your condition:

    _____

    _____

    _____