

**Elbow Intake Survey**  
**Brian J. Cole, MD, MBA**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Email Address \_\_\_\_\_

**Information regarding your current Elbow problem:** When did your shoulder problem begin? \_\_\_/\_\_\_/\_\_\_

Is your problem to the: Right elbow \_\_\_\_\_ Left elbow \_\_\_\_\_ Both elbow \_\_\_\_\_

Work related injury? Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, date injury reported \_\_\_/\_\_\_/\_\_\_

**Please describe your elbow problem:**

1. Problem with your elbow \_\_\_\_\_

2. Was this a result of an injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Was it: Gradual \_\_\_\_\_ Sudden \_\_\_\_\_  
If YES, describe what happened: \_\_\_\_\_  
\_\_\_\_\_

3. Does your elbow feel unstable? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Does your elbow allow you to sleep at night? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Is your elbow problem getting: Worse \_\_\_\_\_ Better \_\_\_\_\_ Staying the same \_\_\_\_\_

6. Date and results if known of imaging studies performed for your elbow:  
a. Xrays: \_\_\_\_\_ c. CT scan: \_\_\_\_\_ e. Other \_\_\_\_\_  
b. MRI: \_\_\_\_\_ d. EMG: \_\_\_\_\_

7. Have you had any of the following non-operative treatment to date:  
a. Physical Therapy: Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, duration and response to PT: \_\_\_\_\_  
b. Non-steroidal anti-inflammatories (NSAIDS): Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, name of NSAID and response to NSAID: \_\_\_\_\_  
c. Cortisone injections: Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, date(s) and response to cortisone injections: \_\_\_\_\_

8. Have you had any surgical procedures on the elbow?: Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, please provide dates, procedure description and surgeon name.

i. Date: ___/___/___	Procedure: _____	MD Name: _____
ii. Date: ___/___/___	Procedure: _____	MD Name: _____
iii. Date: ___/___/___	Procedure: _____	MD Name: _____
iv. Date: ___/___/___	Procedure: _____	MD Name: _____

**Pain and Function questions**

Do you currently have pain in your elbow? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please list the average intensity of pain on scale of 0-10 over the last 7 days  
(0=Normal and 10 = severe pain) \_\_\_\_\_

Describe your pain: \_\_\_\_\_ Dull \_\_\_\_\_ Throbbing \_\_\_\_\_ Aching \_\_\_\_\_ Numbness  
\_\_\_\_\_ Sharp \_\_\_\_\_ Tight \_\_\_\_\_ Burning \_\_\_\_\_ Tingling

How often do you experience pain in your elbow? Never \_\_\_\_\_ Intermittent \_\_\_\_\_ Constant \_\_\_\_\_

Is there anything that helps to alleviate your elbow pain? \_\_\_\_\_

Do you ever take pain medication for your elbow pain? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please list:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
- 4. \_\_\_\_\_ 5. \_\_\_\_\_

Please list any additional information that you feel would be important for us to know regarding the condition of your elbow including what your specific goals and expectations are related to your treatment outcomes:

---

---

---

---

---