

**Mr Nadim Aslam**

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**PRIVATE PRACTICE MANAGER**

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**ALL CORRESPONDENCE**

Bone and Joint Clinic  
Spire South Bank Hospital  
139 Bath Road  
Worcester, WR5 3YB

## Initial Clinic Evaluation Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referring GP: \_\_\_\_\_

**Where is your problem?**  
 Shoulder     Knee     Elbow  
 Neck         Back     Other

**How severe is the pain:** (0 = none, 10 = severe pain)  
At rest?            1 2 3 4 5 6 7 8 9 10  
At its worst?      1 2 3 4 5 6 7 8 9 10

**Which side(s)?**     Right     Left     Both

**Do you have pain at night?**  
 Yes  
 No

**Dominant arm?**     Right                       Left

**Does it waken you from sleep?**  
 Yes  
 No

**Problem(s)?**  
(please check all that apply):  
 Pain  
 Weakness  
 Instability/giving way/dislocation  
 Stiffness  
 Swelling  
 Other

**Are you currently working?**  
 Yes  
 No  
 Retired  
 Normal job?  
 Limited duty?

**How did you injure yourself?**  
 No injury – just started hurting  
 Sports  
 Motor vehicle accident  
 Work/job

**What makes your problem better?**  
\_\_\_\_\_

**Sports level:**     None                       Recreational  
 College                 Professional

**What makes your problem worse?**  
\_\_\_\_\_

**Date of injury:**  
\_\_\_\_\_

**Please describe your current limitations:**  
\_\_\_\_\_

**How long have you had symptoms?**  
Days:  
Months:  
Years:

**Have you had any imaging studies?**  
 X-rays?            Date:  
 MRI?                Date:  
 CT scan?           Date:

**Please briefly describe the injury:**  
\_\_\_\_\_

**Are you interested in surgery to correct your problem?**  
 No  
 Yes  
 Unsure

**Diagnosis?** (If you know or have been told)

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**Previous treatments?**  
(Other than surgery e.g. medications, physiotherapy, injections, bracing)

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**Previous surgery for this problem?** (include dates)

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**Allergies to medication(s)?**

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**Do any diseases run in your family?**  Yes  No

**Medical history:**

**Heart problems?**  Yes  No

**Ulcers/gastritis?**  Yes  No

**Diabetes?**  Yes  No

**Liver problems?**  Yes  No

**Kidney disease?**  Yes  No

**Blood clots?**  Yes  No

**Hepatitis?**  Yes  No

**Cancer?**  Yes  No

**Smoker?**  Yes  No