

Patient/Guardian Signature

Stony Brook Orthopaedic Associates

Wesley V. Carrion, MD Hillary Scheier, PA - C

Patient's Name: _____ DOB: _____ Today's date: _____ Home Phone #: _____ Pt. Height: _____ Pt Weight: _____ Pediatrician: Reason for today's visit: Any changes from previous visit: Location of pain: _____ (Right or Left) Pain described as: Sharp - Dull - Throbbing - Achy - Stiffness - Burning What worsens pain: What improves pain: Moderate Worst Ñο Pain Pain Pain What activities have you not been allowed to participate in that you would like to return to? Thank you for taking the time to fill out the questionnaire, it will help us take better care of you today!

Date