

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Chief Complaint(s) 1 \_\_\_\_\_ 2 \_\_\_\_\_

Is your present problem due to an injury  On the Job  Auto Accident  Personal Injury  Other \_\_\_\_\_

Did your pain begin  Gradually  Suddenly

Is your pain  Constant  Intermittent

Is your pain worse when you  Sit  Bend  Walk  Lift  Push  Pull  Other \_\_\_\_\_

Which of the following areas do you have the most pain, discomfort or restriction of motion

- Neck  Shoulders  Arms  Hands  Upper Back
- Mid Back  Low Back  Pelvis  Hips  Legs
- Knees  Feet  Other \_\_\_\_\_

Using the following chart, how would you rate your pain in percentages when you

Occasionally = 33%  
Frequently = 34-66%  
Constantly = 67-100%

Sit \_\_\_\_\_% of the time  
Stand \_\_\_\_\_% of the time  
Walk \_\_\_\_\_% of the time

Rate the severity of your pain by checking one box on the following scale

10 = Extreme Pain  
1 = least pain

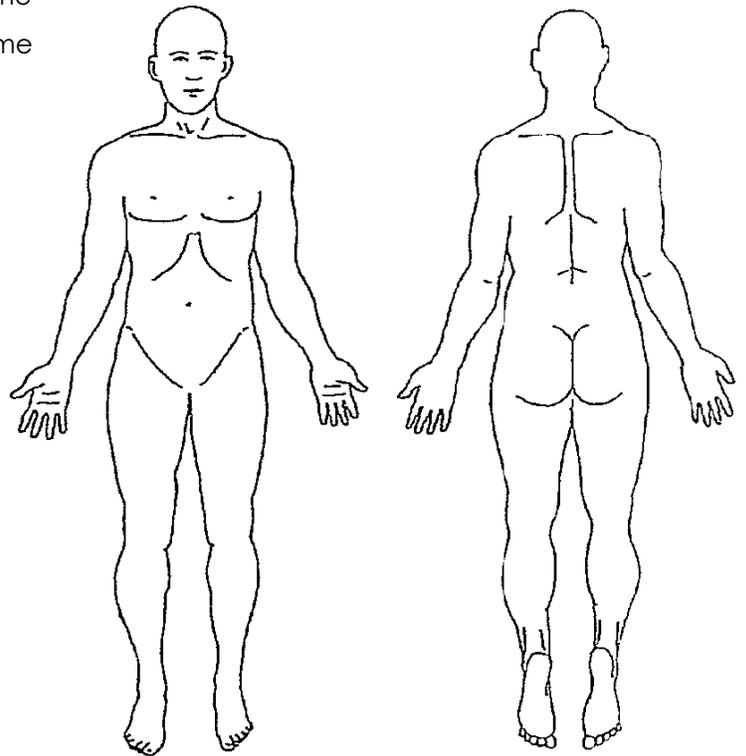
Extreme

10
9
8
7
6
5
4
3
2
1
0

None

Circle the areas of pain on the figure to the right. Then indicate the type of pain using the codes below:

- +++ Burning
- Sharp
- 000 Stabbing
- III Constant



Does your pain interfere with your  Work  Sleep  Daily Routines

Do you feel your present condition is  Temporary  Permanent  Not Sure

List as additional comments you wish to make regarding your condition \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_