Patient Basic Information

Personal Information:

Last Name:	First Name:	Mid. Init.:
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:
Date of Birth:	Date of Injury/Onset:	
Dominant Hand: ❑ Right ❑ Left ❑ Both		
Insurance Information: Policy Holder (if different than patient):		Policy No.:

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Patient Sign & Date:_____ **Date:**_____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
Other_____

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Proceeding along ❑ Slowing down ❑ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑ Mild ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good

Who hit who/what?
❑ You hit other vehicle
❑ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑ Left Front ❑ Right Front
❑ Rear-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑❑ No**
Were you braced for the impact? **Yes❑❑ No**
Did you have a seat belt on? **Yes❑❑ No**
Did you have a shoulder harness on? **Yes❑❑ No**

Does your vehicle have headrests? Yes❑❑ No
What was the position of your headrest at the time of the impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of the impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes❑❑ No** Did passenger side airbags deploy? **Yes❑❑ No** Did side airbags deploy? **Yes❑❑ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes❑❑ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑❑ No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? **Yes❑❑ No**
Was an accident report filled out? **Yes❑❑ No**

10. After the accident:

Check off your symptoms right after and a few days following:
❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands
❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet
❑ Neck stiffness ❑ Confusion ❑ Nervousness ❑ Diarrhea
❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression
❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious
❑ Loss of smell ❑ Irritability ❑ Constipation ❑ Chest Pain
❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor
How did you get there?
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police
Were X-rays done? Yes❑❑ No **Was lab work done?** Yes❑❑ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑ Cervical Collar ❑ Ice **Other:** _____
Medications:_____
Follow-up instructions: _____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑❑ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑❑ No**
Did treatments benefit you? **Yes❑❑ No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑❑ No**
Did treatments benefit you? **Yes❑❑ No**
Last visit date: ____/____/____

Patient Sign & Date:_____ **Date:**_____

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom:

(Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

II. Second Current Symptom:

(Please check off the boxes below to describe your next symptom).

1. Check only one body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

III. Third Current Symptom:

(Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

	L	R	B
Headaches	☐	☐	☐
Front of Head			
Top of Head			
Back of Head			
Jaw	☐	☐	☐
Eye	☐	☐	☐
Neck	☐	☐	☐
Upper Back	☐	☐	☐
Mid Back	☐	☐	☐
Low Back	☐	☐	☐
Chest	☐	☐	☐
Abdomen	☐	☐	☐
Ribs	☐	☐	☐
Buttocks	☐	☐	☐
Shoulder	☐	☐	☐
Upper Arm	☐	☐	☐
Forearm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐ Dull ☐ Sharp ☐ Aching ☐ Cutting
☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping
☐ Spasm ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting

Other types of pain: _____

3. Pain Frequency

☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time
☐ 1/2 to 3/4 of awake time ☐ Most all the time

4. Pain Intensity (How it affects your daily activites)

☐ Doesn't affect ☐ Somewhat affects
☐ Seriously affects ☐ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
Head	☐	☐	☐
Neck	☐	☐	☐
Shoulder	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Hip	☐	☐	☐
Leg	☐	☐	☐
Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending back	☐	☐	☐
Bending left	☐	☐	☐
Bending right	☐	☐	☐
Twisting left	☐	☐	☐
Twisting right	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
	☐	☐	☐
	☐	☐	☐

Patient Sign & Date: _____ **Date:** _____

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

IV. Fourth Symptom:

(Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section)

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

Other types of pain: _____ _____

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

V. Fifth Current Symptom:

(Please check off the boxes below to describe your 5th symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

Other types of pain: _____ _____

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

VI. Sixth Current Symptom:

(Please check off the boxes below to describe your 6th symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations: _____

2. Types of pain

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

Other types of pain: _____ _____

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

Patient Sign & Date: _____ **Date:** _____

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

VII. Seventh Symptom:

(Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section)

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations: _____

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain: _____ _____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects your daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

VIII. Eighth Current Symptom:

(Please check off the boxes below to describe your 8th symptom).

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations: _____

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain: _____ _____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects your daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

IX. Ninth Current Symptom:

(Please check off the boxes below to describe your 9th symptom).

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations: _____

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain: _____ _____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects your daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

Patient Sign & Date: _____ **Date:** _____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty" **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___	Drying hair ___	Brushing teeth ___	Putting on shoes ___	Preparing meals ___	Taking out trash ___
Showering ___	Combing hair ___	Making bed ___	Tying shoes ___	Eating ___	Doing laundry ___
Washing hair ___	Washing face ___	Putting on shirt ___	Putting on pants ___	Cleaning dishes ___	Going to toilet ___

Difficulties with Physical Activities

Standing ___	Walking ___	Kneeling ___	Bending back ___	Twisting left ___	Leaning back ___
Sitting ___	Stooping ___	Reaching ___	Bending left ___	Twisting right ___	Leaning left ___
Reclining ___	Squatting ___	Bending forward ___	Bending right ___	Leaning forward ___	Leaning right ___
Standing for long periods ___		Sitting for long periods ___		Walking for long periods ___	Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___	Lifting weights off floor ___	Pushing things while seated ___	Exercising upper body ___
Carrying large objects ___	Lifting weights off table ___	Pushing things while standing ___	Exercising lower body ___
Carrying brief case ___	Climbing stairs ___	Pulling things while seated ___	Exercising arms ___
Carrying large purse ___	Climbing inclines ___	Pulling things while standing ___	Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___	Jogging ___	Swimming ___	Ice Skating ___	Competitive Sports ___	Dating ___
Golfing ___	Dancing ___	Skiing ___	Roller Skating ___	Hobbies ___	Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___	Riding as a passenger in a motor vehicle ___	Riding as a passenger on a train ___
Driving for long periods of time ___	Riding as a passenger on an airplane ___	Riding as a passenger for long periods ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but have not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (**if applicable**) occured____ ❑ months ago / ❑ years ago **Or on** Date: ____/____/____

Has your History Contributed to your Current Symptoms?

- ❑ My history HAS contributed to my current symptoms.
- ❑ My history HAS NOT contributed to my current symptoms.
- ❑ I 'm NOT SURE if my history has contributed to my current symptoms.

Write in below any other Prior Symptom History, not covered above:

Patient Sign & Date:_____ **Date:**_____