Patient Basic Information

Personal Information:				
Last Name:	First Name	First Name:		
Address:	ress: City, State, Zip:			
Home Phone:	Work Phone:	Social Security No.:		
Date of Birth:	Date of Inju	ıry/Onset:		
Dominant Hand:	nt 🔲 Left	☐ Both		
Insurance Information: Policy Holder (if different than patient):			Policy No.:	
Special Note: If your injury involves paces below to fully describe your spaces. 1. Description of Accident/In Enter a full description of the accident, injury involves the second special s	ur accident, inju njury/Onset	ry or onset, slip	e 2. Otherwise and fall, etc.	, use the
2. Your condition during and Enter the details of your condition during			set	
atient 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 2. Your position in vehicle 3. What was your vehicle doing at the time of the accident? ☐ Car ☐ Station Wagon ☐ Front Passenger ☐ Driver ☐Stopped at intersection ☐Stopped in traffic ☐ Stopped at light ☐ Van ☐ Pickup Truck Left Rear Passenger ☐ Making a right turn ☐ Making a left turn ☐ Parking Large Truck **□**Bus Right Rear Passenger ☐Proceeding along ☐ Slowing down Accelerating Other Other 4. Time/Speed/Damage 5. Details of Accident 6. Road conditions Time of accident Visibility at time of accident Road conditions at time of accident Your vehicle's Poor Fair Good ☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry speed: mph Their vehicle's Who hit who/what? Point of impact speed: ☐ You hit other vehicle mph Head-On ☐Left Front Right Front Damage to your vehicle Other vehicle hit you Rear-End Left Rear Right Rear ☐ Mild ☐ Moderate You hit...(object) ☐ Totaled 7. Body Position, etc. Did you see the accident coming: Yes Q No Does your vehicle have headrests? Yes No Were you braced for the impact? Yes Q No What was the position of your headrest at the time of the impact? Did you have a seat belt on? Yes Q No ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck Did you have a shoulder harness on? Yes Q No 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 \(\bigcup \) No \(\text{Did passenger side airbags deploy}\)? Yes \(\bigcup \) No \(\text{Did side airbags deploy}\)? Yes \(\bigcup \) 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: 10. After the accident: Did your body strike the inside of your vehicle? Yes \ \ \ \ \ No Check off your symptoms right after and a few days following: If yes, describe:_ Headache ☐ Mid back pain ☐ Cold hands Dizziness Did you lose consciousness during the injury? Yes QQ No ☐ Neck pain ■ Nausea ☐ Low back pain ☐ Cold feet If yes, for how long? □Neck stiffness □ Confusion ☐ Nervousness ☐ Diarrhea Your vehicle's estimated damage?_ ☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression Damage to their vehicle: Mild ☐ Moderate ☐ Totaled Ringing in ears Tension ☐ Toe numbness ☐ Anxious Did police show up at the scene? Yes DD No Loss of smell Irritability Constipation Chest Pain Was an accident report filled out? Yes DD No ☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems Others: 11. Emergency Room? 12. Treatment History: Where did you go after the accident? Fill in any other doctor(s) seen prior to your first visit to this office Home ☐ Work Hospital ER ☐ Private Doctor 1. Dr.___ First visit date: 1 1 How did you get there? Specialty: X-rays done? Yes Q No ☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police Types of treatments received: Were X-rays done? Yes ☐☐ No Was lab work done? Yes ☐☐ No How many treatments received?___ Currently treating? Yes Q No Body parts X-rayed? Did treatments benefit you? Yes \ No What lab work? Last visit date: ___/__/ The X-rays revealed: 2. Dr._ First visit date: Treatments: Cervical Collar lice Other: Types of treatments received: Medications: How many treatments received? Currently treating: Yes \ \ \ No Follow-up instructions: Did treatments benefit you? Yes \ \ \ No Last visit date: Patient Sign & Date: Date:

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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 sympto	m. Describe only ONE symptom per Section				
1. Check only one body location below Headaches L R B B	z. Types of pain	Other types of pain:				
Front of Head		utting				
☐Top of Head	☐Throbbing ☐ Burning ☐ Numbing ☐ Ti	ngling				
☐ Back of Head		ounding Constricting				
□Jaw L□ R□ B□	3. Pain Frequency	6. Actions affecting this pain				
DEye L R B	□Up to 1/4 of awake time □1/4 to 1/2 of time	Brings On Aggravates Relieves				
□Neck L □ R □ B □ □UpperBack L □ R □ B □	1/2 to 3/4 of awake time ☐ Most all the time4. Pain Intensity (How it affects your daily	In the A.M.				
UpperBack L□ R□ B□ □MidBack L□ R□ B□	activites)	Bending forward				
□Low Back L □ R □ B □	☐ Doesn't affect ☐ Somewhat affects	☐ Bending back ☐ ☐ ☐				
□Chest L□ R□ B□	☐ Seriously affects ☐ Prevents activities	Bending back				
□Abdomen L □ R □ B □	5. Does this pain radiate into other body parts?	Bending right				
Ribs L R B	Left Right Both	☐ Twisting left ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
□Buttocks L □ R □ B □ □Shoulder L □ R □ B □	Head	Bending forward Bending back Bending left Bending right Twisting left Coughing Sneezing				
OUpperArm LOROBO	Shoulder	Coughing				
□Forearm L□ R□ B□	Arm a a	☐ Straining ☐ ☐				
☐Hand L☐ R☐ B☐	Hand D D	Standing				
□Hip L□ R□ B□	□ Hip □ □ □	Sitting				
OLeg LORD BO	Leg D	Lifting				
Other locations:	Other locations of radiation:					
II. Second Current Symptom:	(Please check off the boxes below to describe you	r next symptom).				
1. Check only one body location below Headaches L R B B	2. Types of pain	Other types of pain:				
Front of Head	Dull Sharp Aching Cu					
☐ Top of Head	☐Throbbing ☐ Burning ☐ Numbing ☐ Tir☐Spasm ☐ Stinging ☐ Shooting ☐ Po	ngling Cramping				
☐ Back of Head	□Spasm □ Stinging □ Shooting □ Po 3. Paln Frequency	unding Constricting 6. Actions affecting this pain				
□Jaw L□ R□ B□ □Eye L□ R□ B□	□Up to 1/4 of awake time □1/4 to 1/2 of time	Brings On Aggravates Relieves				
DEye LD RD BD	☐ 1/2 to 3/4 of awake time ☐ Most all the time	☐ In the A.M. ☐ ☐ ☐				
UpperBack L R B	4. Pain Intensity (How it affects your daily	☐ In the P.M. ☐ ☐ ☐				
☐Mid Back L ☐ R ☐ B ☐	activites) Doesn't affect Somewhat affects	Bending forward				
□Low Back L □ R □ B □	☐ Doesn't affect ☐ Somewhat affects ☐ Prevents activities	Bending back				
Chest L R B	5. Does this pain radiate into other body parts?	Bending left				
□Abdomen L □ R □ B □ □Ribs L □ R □ B □	Left Right Both	Twisting left				
□Buttocks L □ R □ B □	Head	Bending right				
□Shoulder L □ R □ B □	Neck D D	Coughing				
□UpperArm L □ R □ B □	☐ Shoulder ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Bending right Twisting left Coughing Sneezing Straining Standing Sitting				
Forearm L R B	☐ Arm ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Straining				
☐Hand L ☐ R ☐ B ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Hip 0 0	Sitting				
UHip L R B B C	Leg D D	Lifting				
□Foot L□ R□ B□	☐ Foot ☐ ☐ ☐	Other Actions:				
Other locations:	Other locations of radiation:					
III. Third Current Symptom: (F	Please chook off the house below to do with a					
1. Check only one body location below	Please check off the boxes below to describe your 3rd 2. Types of pain	Symptom). Other types of pain:				
□Headaches L □ R □ B □	□ Dull □ Sharp □ Aching □ Cu					
☐ Front of Head☐ Top of Head☐	☐Throbbing ☐ Burning ☐ Numbing ☐ Tin					
Back of Head	□Spasm □ Stinging □ Shooting □ Poi	unding Constricting				
□Jaw L□ R□ B□	3. Pain Frequency	6. Actions affecting this pain				
□Eye L□ R□ B□	☐ 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	Brings On Aggravates Relieves				
□Neck L□ R□ B□	4. Pain Intensity (How it affects your daily	☐ In the A.M. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
☐UpperBack L ☐ R ☐ B ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	activites)	Bending forward				
	☐ Doesn't affect ☐ Somewhat affects	☐ Bending back ☐ ☐ ☐				
ULow Back L □ R □ B □ □Chest L □ R □ B □	Seriously affects Prevents activities	☐ Bending left ☐ ☐ ☐				
□Abdomen L □ R □ B □	5. Does this pain radiate into other body parts?	Bending right				
□Ribs L□ R□ B□	Left Right Both ☐ Head ☐ ☐ ☐	☐ Twisting left ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Buttocks L R B B	☐ Head ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Twisting right ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
UShoulder L R B B		Sneezing				
□UpperArm L □ R □ B □ □Forearm L □ R □ B □	Arm 🔲 🗀	Bending back				
OHand LO RO BO	Hand	□ Standing □ □				
	DHip D D	Sitting				
□Hip L□ R□ B□						
OHip LOROBO	Leg D D D					
□Hip L□ R□ B□	☐ Foot ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Other Actions:				

Patient Sign & Date:_____ Date:____

	Descript				(Describe	your sympto	ms in the se	ctions bel	ow, in the order of seve	erity, if	possib	le.)
	IV. Fourth Syr	nptom:	(Ple	ease check	off the boxes be	elow to desc	ribe your 4th	sympton	n. Describe only ONE	sympt	om per	Section
	Headaches	L 🔲	R 🔲	B 🔲	2. Types of p	pain						of pain:
	□ F	Front of H	ead		Dull	☐ Sharp	Aching		utting	55mm35000		
		Top of He	ad		Throbbing	Burning	Numbin		ngling			
		Back of H		1000 1022000	Spasm		Shootin	g UPo	ounding Constricting			
	Jaw		R 🛄	В	3. Pain Freque				6. Actions affecting	-	-	
	□Eye □Neck		R ☐ R ☐	В П	1/2 to 3/4 of	awake time	☐ Most all #	of time	In the A.M.	gs On A	Aggravates	Relieve
	Upper Back		R	вП	1/2 10 5/4 0/	awake line	- Wost all ti	ie une	In the P.M.	ă	ă	ä
	☐Mid Back	LO	R	вО	4. Pain Intensi	ty (How it aff	ects vour dai	v activites		ā	ā	ā
	Low Back	L	R 🔲	в	☐ Doesn't affe	ct 🔲 S	omewhat af	ects	Bending back			
	Chest	L	R 🔲	в	Seriously aff	ects 🔲 F	revents activ	ities	Bending left			
	Abdomen	L	R 🛄	В	5. Does this pa	in radiate int	o other body	parts?	Bending right			
	□Ribs □Buttocks		R 🔲 R 🛄	В		Left I		oth	☐ Twisting left ☐ Twisting right	Н		
	Shoulder		R	в П в П	Head]	Coughing		000	
	□Upper Arm	LO	R 🗖	вО	☐ Neck☐ Shoulder			3	Sneezing	ā	_	_
	□Forearm	LO	R 🔲	в	Arm	ä			Straining			ā
	Hand	L	R 🔲	в	Hand	ă		=	Standing			
	□Hip	L	R 🛄	в 🛄	☐ Hip	ā		3	Sitting			
	□Leg □Foot		R ☐ R ☐	В □ В □	Leg]	Lifting Other Actions:		u	u
	Other locations		R U	вш	Foot			_	Other Actions:			
					Other location	V-1	-			ā		ă
	V. Fifth Currer	nt Symp	tom:				es below to	describe	your 5th symptom).			
	1. Check only on the check only of the check on the check	ne body			2. Types of p	ain				Othe	r types	of pain:
		ront of H	R 🔲	В	☐ Dull	□ Sharp	Aching	☐ Cı	itting			
		op of Hea			Throbbing	Burning	■ Numbin	g 🗖 Tir				
		Back of He				Stinging	☐ Shooting	☐ Po	unding Constricting			
	Jaw	L	R 🔲	в 🚨	3. Pain Freque				6. Actions affecting			
	□Eye	L 📙	R 🔲	В	1/2 to 3/4 of a	wake time	☐ 1/4 to 1/2	of time	Brings €	On Agg	gravates I	Relieves
	□Neck □Upper Back		R □ R □	В 🔲 В 🔲	— 172 10 07 4 01 8	awake unie	- Wost all ti	e ume	In the P.M.			
	☐Mid Back		R	В	4. Pain Intensit	y (How it affe	ects your dail	y activites	☐ Bending forward			ā
	Low Back	īā	R 🔲	в□	■ Doesn't affect	ot ⊒s	omewhat aff	ects	☐ Bending back			
	Chest	L	R 🔲	в	Seriously aff	ects UP	revents activi	ties	Bending left			0000000
	Abdomen	L	R 🔲	в 🛄	5. Does this pai	n radiate into	other body	parts?	☐ Bending right ☐ Twisting left		H	
	□Ribs □Buttocks		R 🔲	В	legación de la companya de la compan	Left R	ight Bo	th	Twisting left Twisting right			
	Shoulder		R ☐ R ☐	В□	☐ Head ☐ Neck			ם ו	Coughing	ă	ä	ä
	□Upper Arm	ĩ Ö	R	в	Shoulder]	Sneezing			ā
	Forearm	L	R 🔲	в 🗖	Arm	ā	ă ă	i	Straining			
	Hand	L 🛄	R 🔲	в	☐ Hand			j	Standing			
	Hip	L 📙	R 🔲	В	Hip]	☐ Sitting ☐ Lifting			
	□Leg □Foot		R ☐ R ☐	В □ В □	Leg	8		3	Other Actions:	-	_	ч
	Other locations	100	RU	RM	☐ Foot Other locations	Teachers.		4	Other Addons.			
- 1												
-	VI. Sixth Curre 1. Check only or	nt Sym	ocation :	(F	lease check off		elow to desc	cribe your	6th symptom).	Programme and the second		
-	Headaches	L 🔲	R 🔲	B 🔲	2. Types of pa					Other	types o	of pain:
The same of	□Fr	ont of He	ad			Sharp	Aching	Cu Cu				
		p of Head				☐ Burning ☐ Stinging	Numbing		gling Cramping			
	□Ba	ack of Hea	977D G97G97		3. Pain Freque		Shooting	LI Poi	unding Constricting			
Total Control	□ Eye		R ☐ R ☐	В	Up to 1/4 of av		1/4 to 1/2	of time	6. Actions affecting		•	
	□Neck	L 🔲	R 🔲	В 🔲 В 🔲	□1/2 to 3/4 of a	wake time	Most all the	e time	Brings C ☐ In the A.M.		ravates R	Contract Con
	☐Upper Back		R	вО		- Indiana in the second			In the A.M.			
	☐Mid Back	L 🚨	R 🔲	вО	4. Pain Intensity	(How it affe	cts your daily	activites)	Bending forward	ă	ā	5
	Low Back		R 🔲	в 🔲	Doesn't affec		mewhat affe		Bending back			
	Chest		R 🔲	В	Seriously affe		events activit		Bending left			
	□Abdomen □Ribs		R 🔲	В	5. Does this pair			arts?	Bending right			
	Buttocks		R ☐ R ☐	В	Du		ight Bot	5,577	☐ Twisting left☐ Twisting right			H
	Shoulder	נֿם	R	В	☐ Head ☐ Neck				Coughing Coughing	ä		H
	■UpperArm	L 🔲	R 🔲	в 🔲	Shoulder	ä	a a	i	■ Sneezing		ō	ō
	Forearm	L	R 🔲	в 🔲	Arm			i	☐ Straining			
	Hand		R 🔲	В	Hand				Standing			
	□Hip □Leg		R □ R □	В	Hip				Sitting			000000000000
			R	В	☐ Leg ☐ Foot				Lifting Other Actions:			
	Other locations:	THE PARTY OF			Other location			'				
						o or radiati	VII			<u> </u>		<u> </u>
P	atient Sign	& Da	te:				Da	te:				
	3							24.00 m				

Description of Symptoms

VII. Seventh S		CALL TO SERVICE	The second secon	Describe your symptoms in the sections	below, in the order of severity,	if pos	sible.)	
1. Check only of	ne body	n: (Pl	ease check	f the boxes below to describe your 7th s	mptom. Describe only ONE s			
Headaches	L 🔲	R 🔲	В	2. Types of pain		Other	r types	of pain:
	ront of He			Dull Sharp Aching	☐ Cutting		Territor (Street Street	
	op of Hea			Throbbing Burning Numbing	☐ Tingling ☐ Cramping			
	Back of He			□ Spasm □ Stinging □ Shooting	Pounding Constricting			
Jaw	L 🛄	R 🗖	в 🖸	Pain Frequency	6. Actions affecting	, this	pain	
Eye	L 🔲	R 🛄	в 🔲	Up to 1/4 of awake time 1/4 to 1/2 of	time Bring			s Relieves
Neck	L 📙	R 🔲	В	1/2 to 3/4 of awake time Most all the t	ime In the A.M.		Ц	
☐Upper Back ☐Mid Back		R 🔲	В	. Pain Intensity (How it affects your daily a	In the P.M.			
Low Back		R 🔲 R 🔲	В	Doesn't affect Somewhat affect		3		
Chest		R	В 🔲 В 🔾	Seriously affects Prevents activities	Bending left	d		H
Abdomen		RU	вО			$\overline{\Box}$	0000000	0000000000
Ribs	בֿם	R	вО	i. Does this pain radiate into other body pa	Twisting left		ō	ă
Buttocks		R 🔲	вО	Left Right Both ☑ ☐ ☐	☐ Twisting right	ā		$\overline{\Box}$
Shoulder		R	вО	⊒Head □ □ □ □	☐ Coughing			
☐ Upper Arm	L	R 🔲	вО	Shoulder D D	☐ Sneezing			
Forearm	L	R 🔲	в	JArm D D	☐ Straining			
□Hand	L 🔲	R 🔲	в	Hand D D	☐ Standing			
Hip		R 🔲	в	3Hip	Sitting			
Leg		R 🔲	в	Leg D D	Lifting			
☐ Foot	L	R 🔲	в 🔲	Foot 🔲 🗀	Other Actions:			_
Other locations				Other locations of radiation:	-			
VIII. Eighth Cu	irrent S	/mntom:		Please check off the boxes below to de	coribo your 9th oursetern)	Ч_		
1. Check only o	ne body	location	below	Types of pain	scribe your our symptom).	0 11		
Headaches	LOÍ	R 🔲	В□	230 A. C.		Other	types	of pain:
	ront of He				Cutting			
	op of Hea				Tingling Cramping			
	ack of He			Spasm Stinging Shooting Pain Frequency	Pounding Constricting			
Jaw	r 🗖	R 🔲	в 🛄	Up to 1/4 of awake time 1/4 to 1/2 of	6. Actions affecting			
□Eye		R 🔲	В	1/2 to 3/4 of awake time Most all the ti	me In the A.M.		ravates	
Neck	L 📙	R 🗆	В	1/2 to 3/4 of awake time 🚨 Most all the ti	In the P.M.			
Upper Back Mid Back		R	В	Pain Intensity (How it affects your daily a	ctivites) Bending forward		ä	H
Low Back		R 🔲	В	Doesn't affect Somewhat affect			\vec{a}	00000000000
Chest		RU	B □ B □	Seriously affects Prevents activities			000000	
Abdomen		RU	В		—— Dip	ā	ă	ī
Ribs	10	R	В	Does this pain radiate into other body par Left Right Both	ts? Twisting left			
Buttocks		R 🗆	в□	Left Right Both	☐ Twisting right			
Shoulder	īŌ	R 🔲	в□	Neck	☐ Coughing			
□ Upper Arm		R 🗆	вО	Shoulder	☐ Sneezing			
Forearm	L	R 🔲	в	Arm 🗆 🗀	Straining			
Hand	L 🔲	R 🔲	в 🔲	Hand 🔲 🔲	Standing			
□Hip	L	R 🔲	в]Hip 🔲 🔲	Sitting			
Leg		R 🔲	в	leg 🔲 🗎	Lifting			u
Foot		R 🔲	в 🔲	Foot 🔲 🔲	Other Actions:			
Other locations:				ther locations of radiation:				
IX. Ninth Curre	nt Symp	otom:	(F	ase check off the boxes below to describ	e your 9th symptom)			
1. Check only on	e body l	ocation b	elow	Types of pain	o your our dymptom).	Othor	tunno d	of pain:
Headaches	L	R 🔲	в 🚨		По	Other	types o	or pain:
	ont of Hea			Dull Sharp Aching Throbbing Burning Numbing	Cutting			
	p of Head			Spasm Stinging Shooting	Tingling Cramping Pounding Constricting			
	ick of Hea			Pain Frequency	William Control of Con			
□Jaw □Eye		R 🔲	В	Up to 1/4 of awake time 11/4 to 1/2 of t	6. Actions affecting	Participation in the second se		
□ Neck		R □ R □	ВП	11/2 to 3/4 of awake time Most all the time	Billigs U			
		R 🔲	В П В П	and and an inocial the th	me In the A.M.		Н	H
		R	вО	Pain Intensity (How it affects your daily ac	tivites) Bending forward	H		
Low Back	בֿם	R 🔲	в	Doesn't affect			7	
Chest	LO	R 🔲	в	Seriously affects Prevents activities	Bending left	ă		
□Abdomen		R 🔲	в	Does this pain radiate into other body part	s? Bending right	ă	ā	$\overline{}$
□Ribs	L	R 🔲	вП	Left Right Both	☐ Twisting left			ī
	L	R 🔲	в	Head 🔲 🗓	☐ Twisting right		ā	
Shoulder	L	R 🔲	в 🔲	Neck	☐ Coughing			
☐Upper Arm	L	R 🔲	в□	Shoulder	☐ Sneezing		0000	
	L 🛄	R 🛄	в 🔲	IArm 🔲 🔲	☐ Straining			
	L 📙	R 🔲	в	Hand 🔲 🔲	Standing			
		R 🔲	ВО	Hip D D				000000000
	L 📙	R 🔲	ВО	Leg	Lifting			Ц
Other locations:	L	R 🔲	в□	Foot	Other Actions:			
Other locations:				mer locations of ragiation:				
Patient Sign	9 D-	40:						
auciii Siul	ı ox LJ2	ILE.		Date	2 .			

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with re WRITE IN THE APPROPRIATE NUMBER that most closely describe a "I can do it without much difficulty, despite some pain", 3 = "I madespite the pain, but only if I have help", 5 = "I cannot do it at all, be	es your current degree of a nage to do it by myself, de	difficulty: 1 = "I can do i espite marked pain", 4 =	t without any difficulty
Showering Combing hair Making bed	Tying shoes E	Preparing meals	Taking out trash Doing laundry Going to toilet
Sitting Stooping Reaching I Reclining Squatting Bending forward	Bending back	wisting right eaning forward	Leaning left
Carrying large objects Lifting weights off table F Carrying brief case Climbing stairs F	Pushing things while seated Pushing things while standin Pulling things while seated Pulling things while standing	g Exercising	g upper bodyg lower bodyg armsg
Difficulties with Social and Recreational Activities Bowling	ce Skating (Competitive Sports	
Difficulties with Travelling Driving a motor vehicle		Riding as a passenger on Riding as a passenger for	
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 in this area", 4 = " My condition seriously limits my ability in this area", 5			ately restricts my ability
Difficulties with Different Forms of Communication Concentrating Hearing Listening Speaking. Difficulties with the Senses	Reading	Writing Us	ing a keyboard
Seeing Sense of touch	Sense of tas	ste Sense	of smell
Difficulties with Hand Functions Grasping Holding Pinching	Percussive movements	Sensory dis	crimination
Difficulties with Sleep and Sexual Function Being able to have normal, restful nights sleep	Being able to participa	te in desired sexual activ	vity
Write in below any additional information regarding your Activitie	s of Daily Living (that was	n'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 m ☐ My current complaints ALREADY existed and were worsened.	e. My history HAS NO	ntributed to your Cu tributed to my current syr T contributed to my curre v history has contributed to	nptoms. nt symptoms.
My most recent prior similar symptoms (if applicable) occured	months ago / D y	ears ago Or on Date	:
Write in below any other Prior Symptom History, not covered above	/e:		
Patient Sign & Date:	Date:		egatiga — jiir x. ye.iirjii xaa incalliyii isaalii