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.

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
❑ Read-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 stiffnes ❑ 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: ____/____/____

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:			
_____	❑	❑	❑
	❑	❑	❑

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

Other types of pain: _____

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

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

Other types of pain: _____

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

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

Other types of pain: _____

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

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:			
_____	❑	❑	❑
	❑	❑	❑

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:			
_____	❑	❑	❑
	❑	❑	❑

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.

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.

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

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