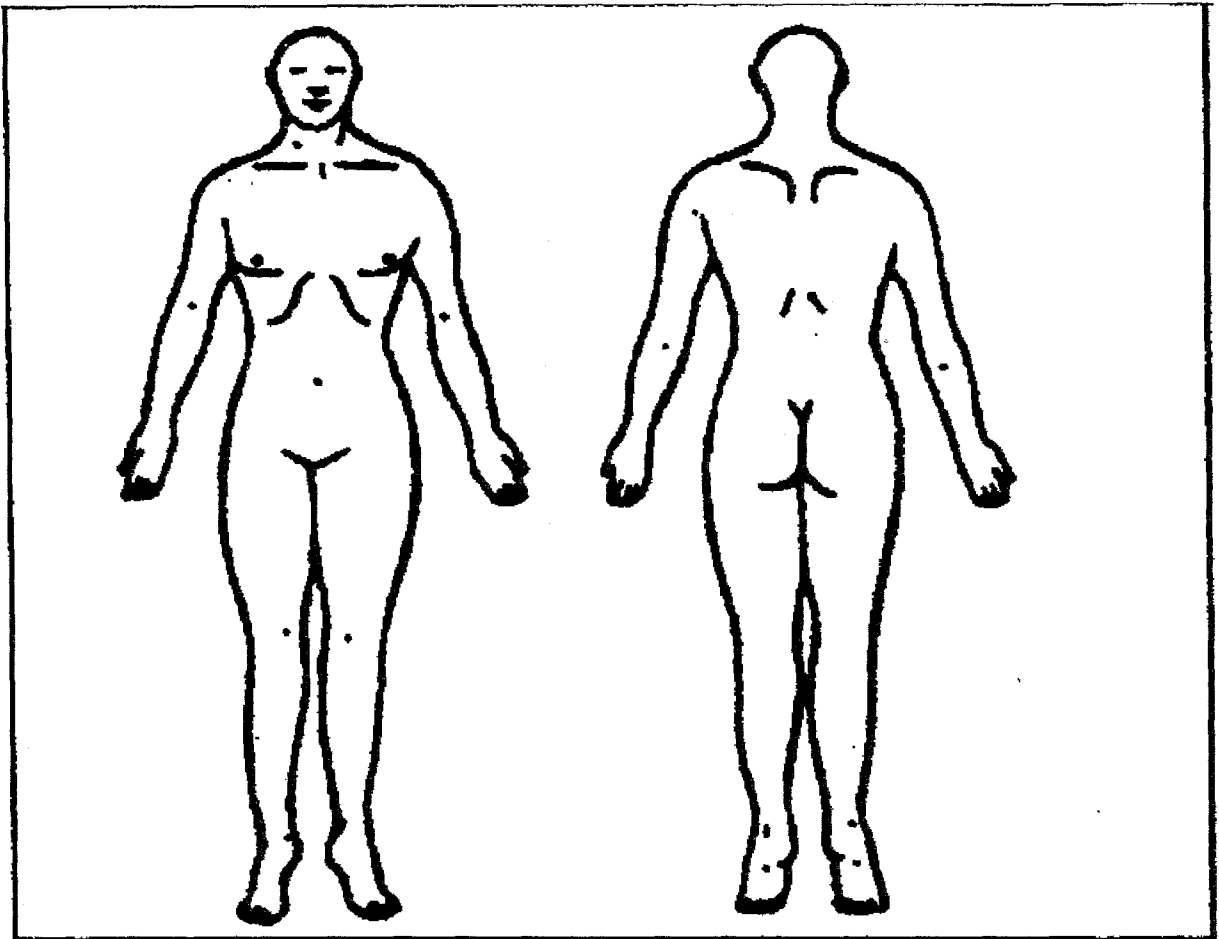


Description of Symptoms

Mark Pain Area

Place an "X" at the location of pain and then describe your pain by placing the symbols below next to the "X"s

Aching	A	Numbness	N	Shooting	H
Burning	B	Sharp	S	Stiffness	W
Constant	C	Tingling	T	Throbbing	R
Dull	D	Cramping	X	Other	O



Mark Pain Severity

(Where 0 is feeling no pain and 10 is feeling severe pain)

Neck	_____
Right Now	0 1 2 3 4 5 6 7 8 9 10
At Its Best	0 1 2 3 4 5 6 7 8 9 10
At Its Worst	0 1 2 3 4 5 6 7 8 9 10
Mid Back	_____
Right Now	0 1 2 3 4 5 6 7 8 9 10
At Its Best	0 1 2 3 4 5 6 7 8 9 10
At Its Worst	0 1 2 3 4 5 6 7 8 9 10
Low Back	_____
Right Now	0 1 2 3 4 5 6 7 8 9 10
At Its Best	0 1 2 3 4 5 6 7 8 9 10
At Its Worst	0 1 2 3 4 5 6 7 8 9 10

Hips	_____
Right Now	0 1 2 3 4 5 6 7 8 9 10
At Its Best	0 1 2 3 4 5 6 7 8 9 10
At Its Worst	0 1 2 3 4 5 6 7 8 9 10
Arms/Hands	_____
Right Now	0 1 2 3 4 5 6 7 8 9 10
At Its Best	0 1 2 3 4 5 6 7 8 9 10
At Its Worst	0 1 2 3 4 5 6 7 8 9 10
Legs/Feet	_____
Right Now	0 1 2 3 4 5 6 7 8 9 10
At Its Best	0 1 2 3 4 5 6 7 8 9 10
At Its Worst	0 1 2 3 4 5 6 7 8 9 10

Patient Basic Information

Date: ___/___/___

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Status: M S D W CHILD Spouse's Name: _____
Social Security No.: _____ Date of Birth: _____ Date of Injury/Onset: _____
Dominant Hand: Right Left Both E-mail Address: _____
Who may we thank for referring you to our office: _____
Insurance Information:
Policy Holder (if different than patient): _____ Policy No.: _____

1. Description of Accident/Injury/Onset *

Are your present problems due to an injury? Yes No On the Job Auto Collision Personal Injury

What was the date of your injury? ___/___/___ Hour: _____ AM PM

Are you now or have you ever been disabled/impaired? (Service or Work?) Yes No When _____

Have you retained an attorney? Yes No Name & Address _____

Were there any witnesses? Yes No Name & Address _____

Did you have any physical complaints before the injury? Yes No Please Describe them in detail: _____

Are you off work? Yes No If yes, when was the last day you worked? ___/___/___

Type of work being done at the time of injury: _____

At this time, are you: Improved Unchanged Getting Worse

Have you ever been involved in an accident before? Yes No if yes, please describe, including dates and types of accidents as well as injuries received: _____

In your own words, please enter a full description of the accident, injury or onset in the space below.

2. During and after Injury details

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

Have you lost time from work as a result of this accident? Yes No If yes, please complete this question

Last day worked: _____

Type of employment: _____

Are you being compensated for time lost from work? Yes No If yes, please state the type of compensation you are receiving: _____

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

Patient Name: _____

Date: ___/___/___

During the accident:

Did you lose consciousness during the injury? Yes No
If yes, for how long? _____

Emergency Room?

Where did you go after the accident?

Home Work Hospital ER Private Doctor

How did you get there?

Self Somebody else Ambulance Police

X-rays done? Yes No Lab work? Yes No

Body parts X-rayed? _____

What lab work? _____

The X-rays revealed: _____

Treatments: Cervical Collar Ice Other: _____

Medications: _____

Follow-up instructions: _____

After the accident:

Check off your symptoms following the accident:

- 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: _____

Treatment History Relative To This Injury:

Fill in 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.)

1. Major Complaint (Current Symptom I): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

- Headaches L R Both
- Front of Head
- Top of Head
- Back of Head

- Jaw L R Both
- Eye L R Both
- Neck L R Both
- Upper Back L R Both
- Mid Back L R Both
- Low Back L R Both
- Chest L R Both
- Abdomen L R Both
- Ribs L R Both
- Buttocks L R Both
- Shoulder L R Both
- Upper Arm L R Both
- Forearm L R Both
- Hand L R Both
- Hip L R Both
- Leg L R Both
- Foot L R Both

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On Aggravates Relieves		
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint

(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 At Its Best 0 1 2 3 4 5 6 7 8 9 10 At Its Worst 0 1 2 3 4 5 6 7 8 9 10

2. Second Complaint (Current Symptom II): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint

(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now	0	1	2	3	4	5	6	7	8	9	10	At Its Best	0	1	2	3	4	5	6	7	8	9	10	At Its Worst	0	1	2	3	4	5	6	7	8	9	10
------------------	---	---	---	---	---	---	---	---	---	---	----	--------------------	---	---	---	---	---	---	---	---	---	---	----	---------------------	---	---	---	---	---	---	---	---	---	---	----

3. Third Complaint (Current Symptom III): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint

(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now	0	1	2	3	4	5	6	7	8	9	10	At Its Best	0	1	2	3	4	5	6	7	8	9	10	At Its Worst	0	1	2	3	4	5	6	7	8	9	10
------------------	---	---	---	---	---	---	---	---	---	---	----	--------------------	---	---	---	---	---	---	---	---	---	---	----	---------------------	---	---	---	---	---	---	---	---	---	---	----

4. Fourth Complaint (Current Symptom IV): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Actions: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint

(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 At Its Best 0 1 2 3 4 5 6 7 8 9 10 At Its Worst 0 1 2 3 4 5 6 7 8 9 10

5. Fifth Complaint (Current Symptom V): (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

1. Check only one body location below

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

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 daily activities)

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

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Actions: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Additional Symptom Information

Please Rate Your Pain Severity For The Above Complaint

(Where 0 is feeling no pain and 10 is feeling severe pain)

Right Now 0 1 2 3 4 5 6 7 8 9 10 At Its Best 0 1 2 3 4 5 6 7 8 9 10 At Its Worst 0 1 2 3 4 5 6 7 8 9 10

Activities of Daily Living Assessment (Only fill in areas affected.)

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"

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 Traveling

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 had not been bothering me.
- My current complaints ALREADY existed and were worsened.
- My most recent prior similar symptoms (if applicable) occurred _____

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.
- _____ months ago / _____ years ago OR on Date: ___/___/___

Additional Historical Data

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

Previous Illnesses (Have You Had Any Of The Following?)

Please enter: "2" (previously), or "3" (presently), in front of all of the following signs and symptoms. If not applicable put NA. A complete history and understanding of your health, will facilitate care. Behind the condition, put the number of times a month that the condition occurs.

General Symptoms

- 784.0 Headaches
- 780.6 Fever
- 780.99 Chills
- 780.8 Night Sweats
- 780.2 Fainting
- 780.4 Dizziness
- 780.3 Convulsions
- 780.52 Loss of Sleep
- 780.7 Fatigue
- 799.2 Nervousness
- 783. Loss of Weight
- 782. Numbness or pain in arms/legs/hands
- 995.3 Allergies
- 786.7 Wheezing
- 729.2 Neuralgia

Muscles and Joints

- 728.9 Weakness
- 781.0 Twitching
- 723.5 Stiff Neck
- 724.5 Backache
- 719.0 Swollen Joints
- 781. Tremors
- 729.5 Foot Trouble
- 724.79 Painful Tailbone
- 724.5 Pain between Shoulders
- 737.3 Spinal Curvature

Gastro-Intestinal

- 783. Poor Appetite
- 536.8 Poor Digestion
- 994.2 Starvation
- 787.3 Belching or Gas
- 787.0 Nausea
- 787.0 Vomiting
- 578.0 Vomiting Blood
- 536.8 Pain over Stomach
- 564.0 Constipation
- 787.91 Diarrhea

- 562.1 Colon Trouble
- 455.6 Hemorrhoids (Piles)
- 776.7 Fluid Retention
- 873.9 Liver Trouble
- 274. Gout
- 782.4 Jaundice
- 575.9 Gall Bladder Trouble

Cardio-Vascular

- 785.0 Rapid Heart Beat
- 427.89 Slow Heart Beat
- 401.9 High Blood Pressure
- 458.9 Low Blood Pressure
- 786.51 Pain over Heart
- 429.9 Heart Trouble
- 719.07 Swelling Ankles
- 459.9 Poor Circulation
- 454.9 Varicose Veins
- 436. Strokes
- 785.1 Palpitations

Eye/Ear/Nose/Throat

- 368.9 Poor Vision
- 378.0 Crossed Eyes
- 379.91 Pain in Eyes
- 389.9 Deafness
- 388.70 Earache
- 388.30 Ear Noises
- 388.60 Ear Discharges
- 478.1 Nasal Obstruction
- 784.4 Nose Bleeds
- 462. Sore Throats
- 784.49 Hoarseness
- 477.9 Hay Fever
- 493.9 Asthma
- 460. Frequent Colds
- 240.9 Enlarged Thyroid
- 463. Tonsillitis
- 473. Sinus Trouble

Skin or Allergies

- 680. Skin Eruptions
- 698.9 Itching
- 924.9 Bruising Easily
- 701.1 Dryness
- 680.9 Boils
- 782. Sensitive Skin
- 708.9 Hives or Allergy
- 692.9 Eczema
- Medicines: _____

Respiratory

- 786.2 Chronic Cough
- 786.3 Spitting Blood
- 786.4 Spitting Phlegm
- 786.50 Chest Pain
- 786.09 Difficulty Breathing

Genito-Urinary

- 788.4 Frequent Urination
- 788.1 Painful Urination
- 599.7 Blood in Urine
- 590. Kidney Infection
- 788.3 Bed Wetting
- 788.3 Inability to control Urine
- 601.9 Prostate Trouble

For Women Only

- 625.3 Painful Periods
- 626.2 Excessive Flow
- 626.4 Irregular Cycle
- 627.2 Hot Flashes
- 625.3 Cramps or Backaches
- 623.5 Vaginal Discharge
- Pregnant at this Time
- Last Pap

By Whom _____
Other _____

Other Health Conditions

- 303.9 Alcoholism
- 280. Anemia
- 541. Appendicitis
- 716. Arthritis
- 239. Cancer
- 052. Chicken Pox
- 250. Diabetes
- 345. Epilepsy
- 240. Goiter
- 429.9 Heart Disease
- 042. HIV Positive
- 487. Influenza
- 055. Measles
- 319. Mental Disorder
- 072. Mumps
- 511. Pleurisy
- 480. Pneumonia
- 045. Polio
- 390. Rheumatic Fever
- 737.30 Scoliosis
- 846. Sprain/Strain Sacroiliac
- 847.0 Whiplash

Additional Historical Data (continued)

Have you ever had any accidents or falls of any kind? List dates:

- Car _____ Recreational Vehicle _____ Sports _____
 School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Have you ever been on crutches? Yes No Why? _____

Have you ever had a lapse of memory? Yes No Have you ever been unconscious? Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these x-rays taken? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Have you had any nervous or mental illnesses? Yes No

Have you ever had psychiatric care? Yes No

If yes, please list the type of care and dates: _____

Are you presently taking any medication – prescription or over-the-counter? Yes No If yes, please list:

Medication

Reason for taking

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Social & Occupational History Section

Occupation _____

Employer _____

Shift 1 2 3 Description _____

Years Worked _____

Work Activity

- Sitting _____%
 Standing _____%
 Light Labor _____%
 Heavy Labor _____%

Exercise

- None
 Moderate
 Daily
 Heavy

Habits

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

- Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Please circle the corresponding time for each activity in a typical 8 hour workday

	1	2	3	4	5	6	7	8	Hours
Sit									
Stand									
Walk									

On the job I perform the following activities: (in terms of an 8 hour workday, "Occasionally" means 33% of the time, "Frequently" means 34% to 66%, and "Continuously" means 67% to 100% of the day)

Activity	Never	Occasionally	Frequently	Continuously
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the job, I lift: (in terms of an 8 hour workday, "Occasionally" means 33% of the time, "Frequently" means 34% to 66%, and "Continuously" means 67% to 100% of the day)

Weight	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have to bend over while doing any lifting? Y N

Are your feet used for repetitive movements, such as operating foot controls? Y N

Do you use your hands for repetitive movements, such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
Right Hand	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Left Hand	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Patient Name: _____

Date: ___/___/___

Social & Occupational History Section (continued)

Are you required to work on unprotected heights? Y N If yes, please describe: _____

Are you required to be around moving machinery? Y N If yes, please describe: _____

Are you exposed to marked changes in temperature and humidity? Y N If yes, please describe: _____

Are you required to drive automotive equipment? Y N If yes, please describe: _____

Are you exposed to dust, fumes, and/or gases? Y N If yes, please describe: _____

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother – Living Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father – Living Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s), # of ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s), # of ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Status Single Married Separated Widowed

Spouse _____
Spouse's Occupation _____
Spouse's Employer _____

List Children (Names and Ages)

Patient Signature _____

Date ___/___/___

The BACK Bournemouth Questionnaire

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

No pain
0 1 2 3 4 5 6 7 8 9 Worst pain possible
10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference
0 1 2 3 4 5 6 7 8 9 Unable to carry out activity
10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference
0 1 2 3 4 5 6 7 8 9 Unable to carry out activity
10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious
0 1 2 3 4 5 6 7 8 9 Extremely anxious
10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed
0 1 2 3 4 5 6 7 8 9 Extremely depressed
10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse
0 1 2 3 4 5 6 7 8 9 Have made it much worse
10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it
0 1 2 3 4 5 6 7 8 9 No control whatsoever
10

Patient name _____ Patient signature _____ Date _____

Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22:503-10

The NECK Bournemouth Questionnaire

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your neck pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry out activity

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry out activity

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse 0 1 2 3 4 5 6 7 8 9 10 Have made it much worse

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it 0 1 2 3 4 5 6 7 8 9 10 No control whatsoever

Patient name _____ Patient signature _____ Date _____

Bolton J, Humphreys BK. The Bournemouth Questionnaire: A short-form comprehensive outcome measure. II. Psychometric properties in neck pain patients. J Manipulative Physiol Ther 2002;25:141-148.