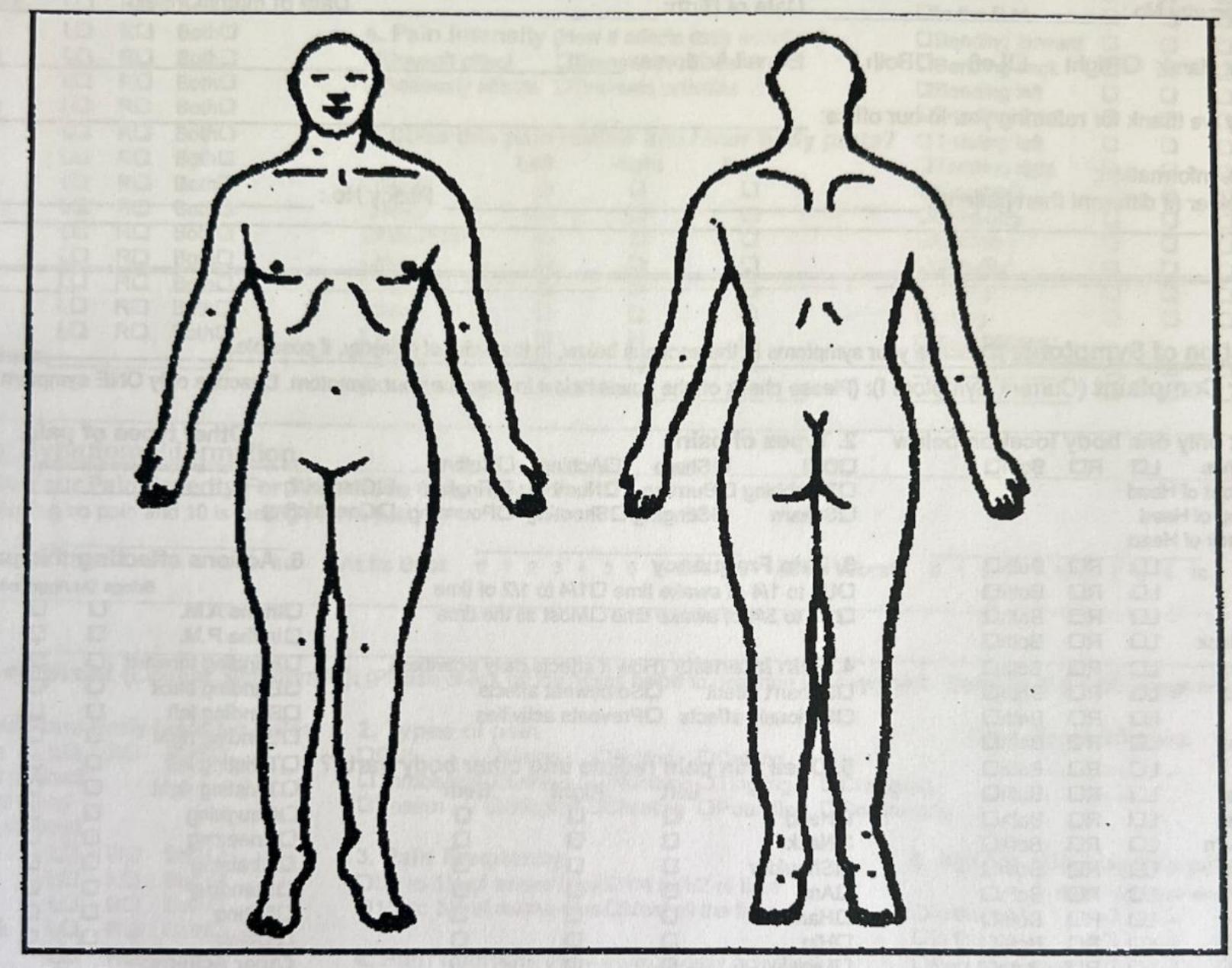
Description of Symptoms

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	Н
Burning	В	Sharp	S	Stiffness	W
Constan	nt C	Tingling	Т	Throbbing	R
Dull	D	Cramping	X	Other	0



Mark Pain Severity (Where 0 is feeling no pain and 10 is feeling severe pain)

Neck		AL LA			3/60			MI			
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						-42					
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				4		ile.		Ling	4		
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	light.	190									
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											
	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: DM DS DD DW DCHILD	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 N	No.:
TENNET SERVICE		
Address: City, State, Zip: 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:		
1. Check only one body location below 2.	Types of pain	Other types of pain:
☐Headaches L☐ R☐ Both☐ ☐		
	Spasm UStinging UShooting UPounding UCo	nstricting
	Pain Fraguency	6 Actions affecting this pain
		□In the P.M. □ □ □
□Mid Back L□ R□ Both□ 4.	Pain Intensity (How it affects daily activities)	☐Bending forward ☐ ☐ ☐
		3
	Seriously affects Prevents activities	
	Dese this pain radiate into other body part	
		□Straining □ □ □
Died ID RD BothD Di	등로 보냈다면 보다 되었다면 하는 것이 있다면 보고 있다면 하는 것이 없는 것이	Genting — —
	_eg U U	
□Foot L□ R□ Both□ □		
Other locations: DI	Foot 🗅 🗅 🗅	
Other locations: DI	Foot 🗅 🗅 🗅	
Other locations: Both Other	Foot 🗅 🗅 🗅	
Other locations: Both O	her locations of radiation:	

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 Name	e:	:nlu/			Date://
2. Second (Com	olaint	(Current Sympton	n II): (Please check off the boxes below to describe your syr	mptom. Describe only ONE symptom per
section.					inproving desired during diffe distribution bei
	ly one		location below	2. Types of pain	Other types of pain:
□Headaches	LO		Both□	□Dull □Sharp □Aching □Cutting	
□Front o		1		□Throbbing □Burning □Numbing □Tingling □Cramp	
□Top of □Back of		-0000		□Spasm □Stinging □Shooting □Pounding □Const	ricting
□Jaw	LO		Both□	3. Pain Frequency	6 Actions affecting this pain
□Eye	LO			□Up to 1/4 of awake time □1/4 to 1/2 of time	6. Actions affecting this pain
□Neck	LO			□1/2 to 3/4 of awake time □Most all the time	□ In the A.M. □ □ □
□Upper Back	LO				OIn the P.M.
☐Mid Back	LO	RO	Both□	4. Pain Intensity (How it affects daily activities)	□Bending forward □ □ □
□Low Back	LO	RO	Both□	□Doesn't affect □Somewhat affects	□Bending back □ □ □
Chest	LO			□Seriously affects □Prevents activities	□Bending left □ □ □
□Abdomen	LO				□Bending right □ □ □
□Ribs □Buttocks	LO			5. Does this pain radiate into other body parts?	
Shoulder	LO			Left Right Both	□Twisting right □ □ □ □ □ □
Upper Arm	LO	Harry and the		DNeck D D	□Coughing □ □ □ □ □
□Forearm	LO			□Shoulder □ □	□Straining □ □
□Hand	LO	RO	Both□		□Standing □ □ □
□Hip	LO	RO	Both□	OHand O O	□Sitting □ □ □
□Leg	ra	RO		OHip O O	□Lifting □ □ □
□Foot	LO.	RO	Both□	OLeg O O	Other Actions:
Other locations	s	(Laren	may male reason	Office locations of radiations	
				Other locations of radiation:	
ection. . Check only	one		location below): (Please check off the boxes below to describe your symposition) 2. Types of pain Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling	Other types of pain:
□Top of H				□Spasm □Stinging □Shooting □Pounding □Const	ricting
□ Back of	PARTIE .				to set in the set of
lJaw	LO	RO	Both D	3. Pain Frequency	6. Actions affecting this pain
lEye INeck	LO	RO RO	Both□ Both□	□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 Relieve
Upper Back	LO	RO	Both□	anz to 314 or awake time alviost all the time	□In the A.M. □ □ □ □ □
Mid Back	LO	RO	Both□	4. Pain Intensity (How it affects daily activities)	□ In the P.M. □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
Low Back	LO	RO	Both□ .	Doesn't affect DSomewhat affects	□Bending lorward □ □ □
Chest	LO	RO	Both□	□Seriously affects □Prevents activities	□Bending left □ □ □
Abdomen	LO	RO	Both□		□Bending right □ □ □
IRibs	LO	RO	Both□	5. Does this pain radiate into other body parts?	□Twisting left □ □ □
Buttocks	LO	RO	Both D	Left Right Both	□Twisting right □ □ □
Shoulder Upper Arm	LO	RO	Both D	□Head □ □ □	□Coughing □ □ □
Forearm	LO	RO RO	Both Both	ONeck O O	□Sneezing □ □ □
Hand	LO	RO	Both	OShoulder O O	OStraining O O
Hip	LO	RO	Both D		□Standing □ □ □ □ □
lLeg	LO	RO	Both	OHip	☐Sitting ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Foot	LO	RO	Both□	OLeg o o	Other Actions:
ther locations	3:			DFoot D D	
				Other locations of radiation:	
		A CONTRACTOR			
dditional S	ymp	tom I	nformation		
lease Rate Y	our F	ain S	everity For The A	bove Complaint	
Vhere 0 is feeli	ing no	pain a	nd 10 is feeling seve	re pain)	
ALL MOM 0	1 2 3	3 4 5	6 7 8 9 10	At Its Best 0 1 2 3 4 5 6 7 8 9 10 At Its Wors	t 0 1 2 3 4 5 6 7 8 9 10

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section.	Com	plaini	(Current Sympton	n IV): (Please of	leck on the	novez new	OW 10 0000	Other type	s of	pain:	
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□Front	A company of the	The state of the s	- Dount	OThrobbing	Quenina	Numbin	g Tingling Cramp	oing			
ПТор о				□Spasm	□Stinging	□ Shooting	Pounding Consti	ricting			
□Back	An Mark Star Vollage and			шорист					45	this -	nin
□Jaw	L		□ Both□	3. Pain Free	quency			6. Actions affec	ung	d sain	Jani
□Eye	L			DUp to 1/4 of		ne 🗆 1/4 to	1/2 of time				ates Relie
□Neck	L			11/2 to 3/4 o				☐In the A.M.			
Upper Back				41/210349	i arrano (ii			☐In the P.M.			
□Mid Back	LE	and the second second		4 Pain Inte	neity (Ho	w it affects	daily activities)	☐Bending forward		0	
DLow Back	LC			Doesn't affe	THE RESERVE OF THE PARTY OF THE	omewhat a	Control of the Contro	☐Bending back			
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Abdomen	LC	24 3M2 NA		accinously a	iicus Lii	revents act		☐Bending right			
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Buttocks	LC			J. Does uns	All the state of t		THE STATE OF THE S	☐Twisting right		0	0
Shoulder				Dillega	Left	Right	Both	□ Coughing	0	0	0
	LC			□Head	u	<u> </u>			0	0	0
Upper Am	LC		A CONTRACTOR OF THE CONTRACTOR	□Neck	0			☐Sneezing	0	0	0
Forearm	LC			DShoulder	0			☐Straining ☐Straining	0	0	0
Hand	LO			□Am □Uand	0			□ Standing	0	0	0
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Leg	LO			OHip				Other Actions:	4	4	3
Foot ther location	r.	RO	Both	OLeg	0	0		Other Actions:	0	0	0
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Fifth Com	plair	it (Cu	rrent Symptom V)	At Its Best 0 : (Please check 2. Types of	off the boo	xes below to	o describe your sympto	om. Describe only O Other type	NE sy	mpton	n per
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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 Name:	Date:/_/_
Additional Historical Data (continued) Have you ever had any accidents or falls of any kind? List dates: Car	
List any broken bones (fractures) or dislocations: Have you ever been on crutches?	
Medication Reason for taking	
Social & Occupational History Section Occupation Employer Shift 1 2 3 Description Years Worked Work Activity Exercise Habits Sitting%	
Please circle the corresponding time for each activity in a typical 8 hour workday Sit 1 2 3 4 5 6 7 8 Hours Stand 1 2 3 4 5 6 7 8 Hours Walk 1 2 3 4 5 6 7 8 Hours	
On the job I perform the following activities: (in terms of an 8 hour workday, "Occasionally" means 33% of the time means 34% to 66%, and "Continuously" means 67% to 100% of the day) Bend/Stoop	
On the job, I lift: (in terms of an 8 hour workday, "Occasionally" means 33% of the time, "Frequently" means 34% to "Continuously" means 67% to 100% of the day)	66%, and
Up to 10 pounds	
Do you use your hands for repetitive movements, such as: Simple Grasping Firm Grasping Fine Manipulation Right Hand Y N Y N Y N Left Hand Y N Y N Y N	

Patient Name: ____

Patien	t Name:				Da	te://_	_
Socia	l & Occupational History	Section (conti	inued)				
Are you	u required to work on unproted	cted heights? Y	□ N □ If yes,	please describe:	March March 19		
Are you	u required to be around movin	g machinery? Y	□ N □ If yes,	please describe:	bed B		
re you	exposed to marked changes	in temperature and	d humidity? Y	□ N □ If yes,	please describe:		
re you	required to drive automotive	equipment? Y 🗆	N □ If yes, pl	ease describe:	The state of		
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	Father - Living Y N				ö	Ö	
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	Sister(s), # UI						
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