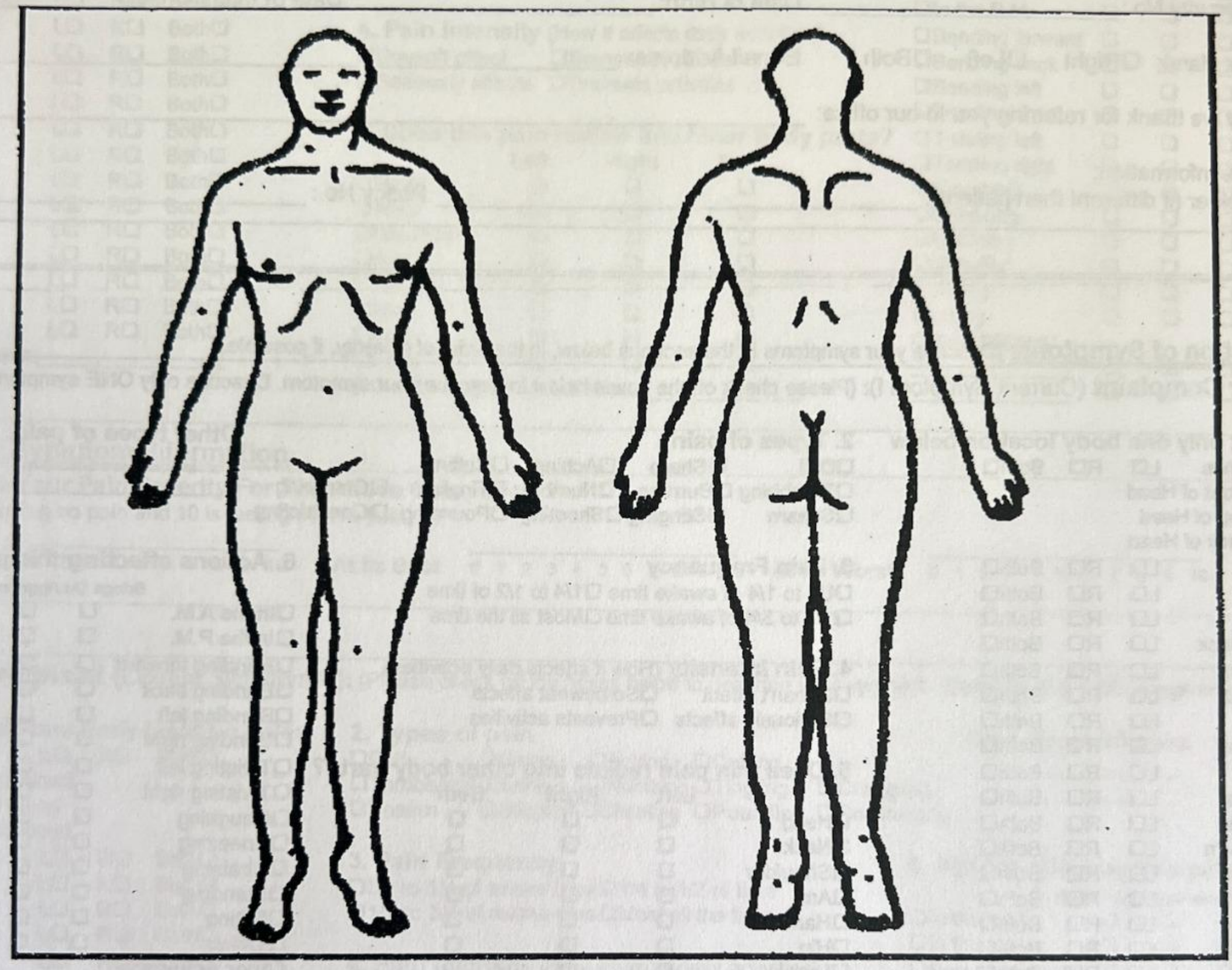
Patient Name: _____ Date: ___/___/___

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.: _____

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
❑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:			
_____	❑	❑	❑
_____	❑	❑	❑

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

Patient Name: _____ Date: ___/___/___

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
❑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:			
_____	❑	❑	❑
_____	❑	❑	❑

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
❑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:			
_____	❑	❑	❑
_____	❑	❑	❑

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

Patient Name: _____ Date: ___/___/___

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
☐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:			
_____	☐	☐	☐
_____	☐	☐	☐

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
☐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:			
_____	☐	☐	☐
_____	☐	☐	☐

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

Patient Name: _____ Date: ___/___/___

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

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 Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

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, "Frequently" means 34% to 66%, and "Continuously" means 67% to 100% of the day)

Bend/Stoop	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Squat	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Crawl	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Climb	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Reach above shoulder level	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Crouch	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Kneel	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Balancing	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
Pushing/Pulling	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously

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)

Up to 10 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
11 to 24 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
25 to 34 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
35 to 50 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
51 to 74 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously
75 to 100 pounds	☐ Never	☐ Occasionally	☐ Frequently	☐ Continuously

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 ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Left Hand	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

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 ☐ N ☐	☐	☐	☐	☐	☐
Father – Living Y ☐ N ☐	☐	☐	☐	☐	☐
Brother(s), # of __	☐	☐	☐	☐	☐
Sister(s), # of __	☐	☐	☐	☐	☐

Status ☐ Single ☐ Married ☐ Separated ☐ Widowed

Spouse _____

Spouse's Occupation _____

Spouse's Employer _____

List Children (Names and Ages):

_____

_____

_____

Patient Signature_____ Date ___/___/___