## **Patient Basic Information**

Personal Information:				
Last Name:		First Name:		Mid. Init.:
Address:		City, State, Zip:		
Home Phone:	Work P	Phone:	Social Security N	lo.:
Date of Birth:	Date of Injury/Onset:	<b>-</b>		
Dominant Hand:	ht	☐ Left ☐ Both	_	
Insurance Information: Policy Holder (if different than patient):			Policy No.:	
Special Note: If your injury invol spaces below to fully describe yo				use the
Description of Accident/ Enter a full description of the accident, in				
<ol> <li>Your condition during ar</li> <li>Enter the details of your condition duri</li> </ol>		nediately after injury/onse	t	
Enter the details of your condition duri		mediately after your injury/onset.		

Patient Sign & 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 ☐ Driver ☐ Stopped in traffic ☐ Stopped at light ☐ Front Passenger ☐ Stopped at intersection ☐ 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 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 ☐ Poor ☐ Fair ☐ Good Your vehicle's ☐ Icv □Wet ☐ Sandy ☐ Dark ☐ Clean and dry speed: \_mph Their vehicle's Who hit who/what? Point of impact speed: mph ☐ You hit other vehicle ☐ 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. Does your vehicle have headrests? Yes□□ No Did you see the accident coming: Yes□□ No Yes□□ No Were you braced for the impact? What was the position of your headrest at the time of the impact? Yes□□ No Did you have a seat belt on? ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck Yes□□ No What was the direction of your head at the time of the impact? Did you have a shoulder harness on? ☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left Did driver side air bags deploy? Yes \(\sigma\) No Did passenger side airbags deploy? Yes \(\sigma\) No Did side airbags deploy? Yes \(\sigma\) 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 \(\bar{\textsf{Q}}\) No Check off your symptoms right after and a few days following: If yes, describe: ☐ Headache Dizziness ☐ Mid back pain ☐ Cold hands Did you lose consciousness during the injury? Yes□□ No ☐ Neck pain □ Nausea ☐ Low back pain ☐ Cold feet If yes, for how long? ☐ Nervousness ☐ Diarrhea □ Neck stiffness □ Confusion ☐ Loss of taste ☐ Depression ☐ Fainting ☐ Fatique Your vehicle's estimated damage?\_ ■ Moderate □ Totaled ☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious Yes I No ☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain Did police show up at the scene? Was an accident report filled out? Yes□□ No ☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems Others: 11. Emergency Room? 12. Treatment History: Fill in any other doctor(s) seen prior to your first visit to this office Where did you go after the accident? Home ☐ Work ☐ Hospital ER ☐ Private Doctor 1. Dr. First visit date: Yes□□ No How did you get there? Specialty:\_\_\_\_ \_\_\_\_\_ X-rays done? ☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police Types of treatments received: How many treatments received? \_\_\_\_ Currently treating? Yes □ □ No Did treatments benefit you? Yes□□ No Body parts X-rayed? Last visit date: \_\_\_\_/\_\_\_/\_\_ What lab work? First visit date: \_\_\_\_/\_\_\_/ The X-rays revealed: \_ 2. Dr. Treatments: ☐ Cervical Collar ☐ Ice Other: Types of treatments received: How many treatments received? \_\_\_\_ Currently treating: Yes \(\sigma\) No Medications: Follow-up instructions: Did treatments benefit you? Yes \(\bar{\pi}\) No Last visit date:

Patient Sign & Date:

Date:

Description of Symptoms	· •	escribe your symptoms in the sections below, in the order of severity, if po	<u> </u>
I. First Current Symptom: (Please 1. Check only one body location below)	check o	off the boxes below to describe your first symptom. Describe only ONE 2. Types of pain	symptom per Section Other types of pain:
□Headaches L □ R □ E	в□	☐ Dull ☐ Sharp ☐ Aching ☐ Cutting	Other types or pain.
☐Front of Head		□Throbbing □ Burning □ Numbing □ Tingling □ Cramping	
☐Top of Head ☐Back of Head		□Spasm □ Stinging □ Shooting □ Pounding □ Constricting	
□Jaw L □ R □ E		3. Pain Frequency 6. Actions affecting	this pain gs On Aggravates Relieves
		□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 □ In the A.M.	Aggiavates itelieves
□Neck L □ R □ E □Upper Back L □ R □ E		<b>4. Pain Intensity</b> (How it affects your daily	
☐Mid Back L ☐ R ☐ E	в 🔲 📗	activites) ☐ Bending forward ☐ Doesn't affect ☐ Somewhat affects ☐ Bending back	
□Low Back L □ R □ E		☐ Doesn't affect ☐ Somewhat affects ☐ Bending back ☐ Seriously affects ☐ Prevents activities ☐ Bending left	
	В 🔲   В 🔲	5 Does this pain radiate into other body parts?	
	в	Left Bight Both   □ IWISTING IEπ	
□Buttocks L □ R □ E	в 🔲 📗	Head Twisting right Coughing	
	В	□ Neck □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	
□Upper Arm L □ R □ E □Forearm L □ R □ E	В 🔲   В 🔲	□ Straining	
□Hand L □ R □ E	в	Hand	000000000000000000000000000000000000000
	В 🔲	Hip Sitting Leq Lifting	
	В 🔲   В 🔲	Leg Cher Actions:	
Other locations:		Other locations of radiation:	
II. Second Current Symptom:		(Please check off the boxes below to describe your next symptom).	
1. Check only one body location belo		2. Types of pain	Other types of pain:
	в 🔲	☐ Dull ☐ Sharp ☐ Aching ☐ Cutting	
☐ Front of Head ☐ Top of Head		☐Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping	
☐Back of Head		□ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin  3. Pain Frequency 6. Actions affecting	
	в 💶 📗		us On Aggravates Relieves
		□1/2 to 3/4 of awake time □ Most all the time □ In the A.M.	
Upper Back L R R B		<b>4. Pain Intensity</b> (How it affects your daily activites) ☐ In the P.M. ☐ Bending forward	
☐Mid Back L ☐ R ☐ E	в 🔲	☐ Doesn't affect ☐ Somewhat affects ☐ Bending forward ☐ Bending back	
□Low Back L □ R □ E □Chest L □ R □ E	в 🔲   в 🔲	☐ Seriously affects ☐ Prevents activities ☐ Bending left	
□Chest L □ R □ E □Abdomen L □ R □ E	В	5. Does this pain radiate into other body parts?	
□Ribs L □ R □ E	в 🔲	Left Right Both ☐ Twisting left ☐ Head ☐ ☐ ☐ ☐ Twisting right	
Buttocks L R R B	В	□ Neck □ □ □ □ Coughing	
□Shoulder L □ R □ E □Upper Arm L □ R □ E	в 🔲 в 🔲	□ Shoulder     □     □     □ Sneezing       □ Arm     □     □     □ Straining       □ Hand     □     □     □ Standing	
□Forearm L □ R □ E	в	☐ Arm ☐ ☐ ☐ Straining ☐ Hand ☐ ☐ Straining ☐ Standing	
□Hand L □ R □ E	в 🔲	☐ Hip ☐ ☐ ☐ ☐ Sitting	
	В <b>П</b> В <b>П</b>	□ Leg □ □ □ Lifting	
	В	☐ Foot ☐ ☐ ☐ Other Actions:	
Other locations:		Other locations of radiation:	
II. Third Current Symptom:		lease check off the boxes below to describe your 3rd symptom).	
<ol> <li>Check only one body location belo</li> <li>□Headaches L □ R □ B</li> </ol>	ow B □	2. Types of pain	Other types of pain:
☐ Front of Head	_	☐ Dull ☐ Sharp ☐ Aching ☐ Cutting ☐ Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping	
☐Top of Head		□Spasm □ Stinging □ Shooting □ Pounding □Constrictin	<u></u>
□Back of Head □Jaw L □ R □ B	в 🗖 🗍	3. Pain Frequency 6. Actions affecting	this pain
□Eye L□ R□ B	в 🔲	□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 □ In the A.M.	s On Aggravates Relieves
□Neck L□ R□ B	в 🔲 📙	4. Pain Intensity (How it affects your daily	
	ВЦ	activites)	
		☐ Doesn't affect ☐ Somewhat affects ☐ Bending back	
☑Mid Back L ☑ R ☑ B ☑Low Back L ☑ R ☑ B			
□Low Back L □ R □ B □Chest L □ R □ B	В 🔲   В 🔲  -	☐ Seriously affects ☐ Prevents activities  5 Does this pain radiate into other body parts? ☐ Bending left ☐ Bending right	
□Low Back L □ R □ B □Chest L □ R □ B □Abdomen L □ R □ B	B 🔲   B 🔲	☐ Seriously affects ☐ Prevents activities  5. Does this pain radiate into other body parts?  Left Right Both  Twisting left  Twisting left	
□Low Back	B	Seriously affects □ Prevents activities □ Bending left  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ Twisting left □ Twisting right	
□Low Back         L         □         R         □         B           □Chest         L         □         R         □         B           □Abdomen         L         □         R         □         B           □Ribs         L         □         R         □         B           □Buttocks         L         □         R         □         B           □Shoulder         L         □         R         □         B		Seriously affects □ Prevents activities  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ Twisting left □ Neck □ □ □ □ Coughing	
□Low Back         L         □         R         □         B           □Chest         L         □         R         □         B           □Abdomen         L         □         R         □         B           □Ribs         L         □         R         □         B           □Buttocks         L         □         R         □         B           □Shoulder         L         □         R         □         B           □Upper Arm         L         □         R         □         B		□ Seriously affects □ Prevents activities  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ □ Twisting right □ Neck □ □ □ □ □ Coughing □ Shoulder □ □ □ □ Straining	
□Low Back         L         □         R         □         B           □Chest         L         □         R         □         B           □Abdomen         L         □         R         □         B           □Ribs         L         □         R         □         B           □Buttocks         L         □         R         □         B           □Shoulder         L         □         R         □         B           □Upper Arm         L         □         R         □         B           □Forearm         L         □         R         □         B		□ Seriously affects □ Prevents activities  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ □ Twisting right □ Neck □ □ □ □ □ Coughing □ Shoulder □ □ □ □ Straining	
□Low Back         L         □         R         □         B           □Chest         L         □         R         □         B           □Abdomen         L         □         R         □         B           □Ribs         L         □         R         □         B           □Buttocks         L         □         R         □         B           □Shoulder         L         □         R         □         B           □Upper Arm         L         □         R         □         B           □Forearm         L         □         R         □         B           □Hand         L         □         R         □         B		Seriously affects □ Prevents activities □ Bending left  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ □ Twisting right □ Neck □ □ □ □ □ Coughing □ Shoulder □ □ □ □ Straining □ Hand □ □ □ □ Standing □ Hip	
□Low Back         L         □         R         □         B           □Chest         L         □         R         □         B           □Abdomen         L         □         R         □         B           □Ribs         L         □         R         □         B           □Shoulder         L         □         R         □         B           □Upper Arm         L         □         R         □         B           □Forearm         L         □         R         □         B           □Hand         L         □         R         □         B           □Hip         L         □         R         □         B           □Leg         L         □         R         □         B		□ Seriously affects □ Prevents activities  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ □ Twisting right □ Neck □ □ □ □ □ Coughing □ Shoulder □ □ □ □ Straining	
□Low Back       L       □       R       □       B         □Chest       L       □       R       □       B         □Abdomen       L       □       R       □       B         □Ribs       L       □       R       □       B         □Buttocks       L       □       R       □       B         □Shoulder       L       □       R       □       B         □Upper Arm       L       □       R       □       B         □Hand       L       □       R       □       B         □Hip       L       □       R       □       B         □Leg       L       □       R       □       B         □Foot       L       □       R       □       B		Seriously affects □ Prevents activities □ Bending left  5. Does this pain radiate into other body parts?  Left Right Both □ Head □ □ □ □ □ Twisting right □ Neck □ □ □ □ □ Sneezing □ Arm □ □ □ □ Straining □ Hand □ □ □ □ Standing □ Hip □ □ □ □ □ Lifting	
□Low Back       L       □       R       □       B         □Chest       L       □       R       □       B         □Abdomen       L       □       R       □       B         □Ribs       L       □       R       □       B         □Buttocks       L       □       R       □       B         □Shoulder       L       □       R       □       B         □Upper Arm       L       □       R       □       B         □Forearm       L       □       R       □       B         □Hand       L       □       R       □       B         □Hip       L       □       R       □       B         □Leg       L       □       R       □       B		Seriously affects Prevents activities Bending left  5. Does this pain radiate into other body parts?  Left Right Both Twisting right Twisting right Twisting right Coughing Shoulder Arm Shoulder Hand Hip Hip Leg Foot  Prevents activities Bending left Twisting left Twisting right Coughing Shoezing Straining Standing Standing Lifting Cother Actions:	

	off the boxes below to describe your 4th symptom.	Describe only ONE symptom per Section
1. Check only one body location below ☐Headaches L ☐ R ☐ B ☐	2. Types of pain	Other types of pain:
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	□ Dull □ Sharp □ Aching □ Cu	
☐Top of Head	☐Throbbing ☐ Burning ☐ Numbing ☐ Tin	
☐Back of Head		unding ☐Constricting  6. Actions affecting this pain
	3. Pain Frequency ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time	Brings On Aggravates Relieves
□Eye L □ R □ B □ □ Neck L □ R □ B □	$\square$ 1/2 to 3/4 of awake time $\square$ Most all the time	☐ In the A.M. ☐ ☐ ☐
Upper Back L R B B		☐ In the P.M. ☐ ☐ ☐
☐Mid Back L ☐ R ☐ B ☐	4. Pain Intensity (How it affects your daily activites)	☐ Bending forward ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
□Low Back L □ R □ B □	☐ Doesn't affect ☐ Somewhat affects ☐ Prevents activities	☐ Bending back ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐Chest L ☐ R ☐ B ☐ ☐ ☐Abdomen L ☐ R ☐ B ☐	•	☐ Bending right ☐ ☐ ☐
□Abdomen L □ R □ B □ □Ribs L □ R □ B □	5. Does this pain radiate into other body parts?	☐ Twisting left ☐ ☐ ☐
Buttocks L R B B	Left Right Both ☐ Head ☐ ☐ ☐	Twisting right
□Shoulder L □ R □ B □	□ Neck □ □ □	Coughing
Upper Arm L R B B	☐ Shoulder ☐ ☐ ☐	Straining
□Forearm L □ R □ B □ □Hand L □ R □ B □	Arm D D	☐ Standing ☐ ☐ ☐
	□ Hand □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	☐ Sitting ☐ ☐ ☐
□Leg L□ R□ B□		Lifting
□Foot L □ R □ B □	G Foot	Other Actions:
Other locations:	Other locations of radiation:	
V. Fifth Current Symptom:	(Please check off the boxes below to describe	
1. Check only one body location below	2. Types of pain	Other types of pain:
☐Headaches L ☐ R ☐ B ☐ ☐Front of Head	☐ Dull ☐ Sharp ☐ Aching ☐ Cu	
☐ Front of Head☐ Top of Head☐	☐Throbbing ☐ Burning ☐ Numbing ☐ Tin	gling Cramping
☐Back of Head	□Spasm □ Stinging □ Shooting □ Po  3. Pain Frequency	unding Constricting  6. Actions affecting this pain
□Jaw L□ R□ B□	☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time	Brings On Aggravates Relieves
□Eye L □ R □ B □ □ Neck L □ R □ B □	□1/2 to 3/4 of awake time □ Most all the time	☐ In the A.M. ☐ ☐ ☐
Upper Back L R B B		☐ In the P.M. ☐ ☐ ☐
☐Mid Back L ☐ R ☐ B ☐	<b>4. Pain Intensity</b> (How it affects your daily activites)  ☐ Doesn't affect ☐ Somewhat affects	☐ Bending forward ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
□Low Back L □ R □ B □	☐ Seriously affects ☐ Prevents activities	Bending left
☐Chest L☐ R☐ B☐ ☐Abdomen L☐ R☐ B☐	,	☐ Bending right ☐ ☐ ☐
□Abdomen L □ R □ B □ □Ribs L □ R □ B □	5. Does this pain radiate into other body parts?  Left Right Both	Twisting left Twisting right Coughing Sneezing Straining
□Buttocks L □ R □ B □	Head	☐ Twisting right ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
☐Shoulder L ☐ R ☐ B ☐	Neck	Coughing
Upper Arm L R B B	□ Shoulder □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	☐ Straining ☐ ☐ ☐
□Forearm L □ R □ B □ □Hand L □ R □ B □	Hand	Standing
I □Hip L □ R □ B □	☐ Hip ☐ ☐	Sitting
Leg L R B B	Leg	Lifting
□Foot L□ R□ B□	Foot	
Other locations:	Other locations of radiation:	
	Please check off the boxes below to describe your	
1. Check only one body location below ☐Headaches L ☐ R ☐ B ☐	2. Types of pain	Other types of pain:
☐Front of Head	□ Dull □ Sharp □ Aching □ Cu □ Throbbing □ Burning □ Numbing □ Tin	
☐Top of Head		unding Constricting
□Back of Head □Jaw L □ R □ B □	3. Pain Frequency	6. Actions affecting this pain
DEye L R B B	Up to 1/4 of awake time  1/4 to 1/2 of time	Brings On_ Aggravates Relieves
□Neck L□ R□ B□	□1/2 to 3/4 of awake time □ Most all the time	☐ In the A.M. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Upper Back L R B B	4. Pain Intensity (How it affects your daily activites)	
☐ Mid Back L ☐ R ☐ B ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Doesn't affect ☐ Somewhat affects	Bending back
Chest L R B B	☐ Seriously affects ☐ Prevents activities	☐ Bending left ☐ ☐ ☐
□Abdomen L □ R □ B □	5. Does this pain radiate into other body parts?	Bending right
	Left Right Both	Twisting left
□Buttocks L □ R □ B □ □Shoulder L □ R □ B □	Head	
Upper Arm L R B B	Shoulder	☐ Sneezing ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
□Forearm L □ R □ B □	□ Arm □ □ □	Straining
□Hand L□ R□ B□	Hand	Bending right Twisting left Coughing Sneezing Straining Standing Sitting
□Hip L□ R□ B□ □Leg L□ R□ B□	☐ Hip ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Sitting ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
□Leg L□ R□ B□ □Foot L□ R□ B□	Leg	Other Actions:
Other locations:	Other locations of radiation:	
Patient Sign & Date:	Date:	

(Describe your symptoms in the sections below, in the order of severity, if possible.)

**Description of Symptoms** 

			off the boxes below to describe your 7th symptom. Describe only ON		
	e body location I	below B 🔲	2. Types of pain	Other	types of pain
	ont of Head	ь <b>ц</b>	☐ Dull ☐ Sharp ☐ Aching ☐ Cutting		
	p of Head		☐Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Cramping		
	ck of Head		□Spasm □ Stinging □ Shooting □ Pounding □Constrict		
□Jaw	L 🔲 R 🔲	в 🗖	3. Pain Frequency 6. Actions affect		
	L 🔲 R 🔲	в 🗖			gravates Relieve
□Neck	L 🔲 R 🔲	в 🗖	□1/2 to 3/4 of awake time □ Most all the time □ In the A.M.		
	L 🔲 R 🔲	в 🗖	☐ In the P.M.	. 📙	
☐Mid Back	L 🔲 R 🔲	в 🗖	4. Pain Intensity (How it affects your daily activities) Bending forward		
	L 🔲 R 🛄	в 🛄	☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Prevents activities ☐ Bending back ☐ Bending left		
	L 🔲 R 🛄	в 🔲	☐ Seriously affects ☐ Prevents activities ☐ Bending left ☐ Bending right		
	L R R	в 🔲	5. Does this pain radiate into other body parts?	- H	
	L R R	В	Left Right Both   Twicting right	- i	<u> </u>
	L R R	В	Head U U Coughing	☐	<u> </u>
	L D R D	В	U Neck U U Casarina		<u> </u>
	L R R R R	в <b>□</b> в <b>□</b>	Shoulder U U Ctraining		
	L  R	ВП	☐ Arm ☐ ☐ Standing		
		В	Hand U U   Dicition		
	L  R	В	HIP U U I I I I I I I I I I I I I I I I I		
	L R R	в			
Other locations:		ь <b>ц</b>		_ 🗆	
			Other locations of radiation:		
	rent Symptom:		(Please check off the boxes below to describe your 8th symptom).		
	ne body location		2. Types of pain	Other	types of pain
Headaches	L C R C	В	□ Dull □ Sharp □ Aching □ Cutting	_	
	ont of Head		☐Throbbing ☐ Burning ☐ Numbing ☐ Tingling ☐ Crampir		
	p of Head ack of Head		□Spasm □ Stinging □ Shooting □ Pounding □Constrict		
□Jaw	L R R	в 🗖	3. Pain Frequency 6. Actions affect		•
□Eye		в			ravates Relieves
□Neck	L R	в 🗖	$\square$ 1/2 to 3/4 of awake time $\square$ Most all the time $\square$ In the A.M.		
☐Upper Back	L R	в 🗖	☐ In the P.M.	. 📮	
☐Mid Back	L R	в 🗖	4. Pain Intensity (How it affects your daily activities) Bending forward		
☐Low Back	L 🔲 R 🔲	в 🗖	□ Doesn't affect □ Somewhat affects □ Bending back		
□Chest	L 🔲 R 🔲	в 🗖	☐ Seriously affects ☐ Prevents activities ☐ Bending left ☐ Rending right		
□Abdomen	L 🔲 R 🔲	в 🔲	5. Does this pain radiate into other body parts?	=	
□Ribs	L 🔲 R 🔲	в 🗖	Left Right Both Twisting right		
□Buttocks	L 🔲 R 🔲	в 🔲	☐ Head ☐ ☐ ☐ ☐ Twisting right		
□Buttocks □Shoulder	L R R R	в <b>П</b> в <b>П</b>	Head		
□Buttocks □Shoulder □UpperArm	L	В <b>□</b> В <b>□</b> В <b>□</b>	Head		
□Buttocks □Shoulder □Upper Arm □Forearm	L	В 🔲 В 🔲 В 🔲	Head		
□Buttocks □Shoulder □Upper Arm □Forearm □Hand	L	В 🔾 В 🔾 В 🔾 В 🔾	Head		
□Buttocks □Shoulder □Upper Arm □Forearm □Hand □Hip	L	B	Head		
□Buttocks □Shoulder □Upper Arm □Forearm □Hand □Hip □Lea	L	B	Head	000000	
□Buttocks □Shoulder □Upper Arm □Forearm □Hand □Hip □Leg □Foot	L	B	Head	_ _ _	
□Buttocks □Shoulder □Upper Arm □Forearm □Hand □Hip □Leg □Foot Other locations:	L	B B B B B B B B	Head	000000	
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations:	L	B	Head	-	
□ Buttocks □ Shoulder □ Upper Arm □ Forearm □ Hand □ Hip □ Leg □ Foot Other locations:  IX. Ninth Currer  1. Check only on	L R R R R R R R R R R R R R R R R R R R	B	Head	-	
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only on	L	B	Head	Other	
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches	L R R R R R R R R R R R R R R R R R R R	B	Head	Other	
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only on	R R R R R R R R R R R R R R R R R R R	B	Head	Other	
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches	R R R R R R R R R R R R R R R R R R R	B	Head	Other	types of pain
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches Gro Bac	R R R R R R R R R R R R R R R R R R R	B	Head	Other  og ing this    gg On_Aggr	types of pain  pain ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches Fro Jaw Jaw Eye	L R R L R R L R R R R R R R R R R R R R	B	Head	Other  ging this I	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Froe Jaw Eye Neck Upper Back	R	B	Head	Other  gg ing this   ggs On Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Horearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches Top Daw Eye Neck Upper Back	R	B	Head	Other  ing this I	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Top Jaw Eye Neck Upper Back Mid Back Low Back	L	B	Head	Other  Ing ing this I	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Fro Jaw Eye Neck Upper Back Mid Back Low Back	L  R  R  R  R  R  R  R  R  R  R  R  R  R	B	Head	Other  org  ing this page on Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Jaw Eye Neck Upper Back Mid Back Chest Abdomen	L  R  R  R  R  R  R  R  R  R  R  R  R  R	B	Head	Other  org  ing this page on Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Jaw Eye Neck Upper Back Mid Back Chest Abdomen Ribs	R	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing Ing this I	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks	L  R  R  R  R  R  R  R  R  R  R  R  R  R	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer Check only one Headaches Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder	L	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing ing this    Ings On Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only on Headaches Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm	L	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing ing this I	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only on: Headaches Fro Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm	L	B B B B B B B B B B B B B B B B B B B	Head	Other  og ing this    ogs On Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only on: Headaches Fro Jaw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand	L	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing ing this    Ings On Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches Froe Back Upper Back Upper Back Upper Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand Hip	L	B B B B B B B B B B B B B B B B B B B	Head	Other  og ing this    ogs On Aggr	types of pain  pain  avates Relieves
Buttocks Shoulder Upper Arm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches Froe Daw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand Hip Leg	L	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing ing this    Ings On Aggr	types of pain  pain  ravates Relieves
Buttocks Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations: IX. Ninth Currer 1. Check only one Headaches Froe Daw Eye Neck Upper Back Mid Back Low Back Chest Abdomen Ribs Buttocks Shoulder Upper Arm Forearm Hand Hip Leg	L	B B B B B B B B B B B B B B B B B B B	Head	Other  Ing ing this    Ing Son Aggre	types of pain  pain  ravates Relieves

(Describe your symptoms in the sections below, in the order of severity, if possible.)

**Description of Symptoms** 

Patient Sign & Date:\_\_\_\_\_ Date:\_\_\_\_

## **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 ...... Kneeling for long periods ..... Kneeling 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 ...... Pulling things while seated ...... Exercising arms .....\_\_\_\_ Carrying large purse ...... Climbing inclines ..... Pulling things while standing .... 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** Has your History Contributed to your Current Symptoms? ☐ I have NOT had prior symptoms similar to my current complaints. ☐ 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 current complaints DID exist before, but have not been bothering me. ☐ My current complaints ALREADY existed and were worsened. months ago / years ago Or on Date: My most recent prior similar symptoms (if applicable) occured....... Write in below any other Prior Symptom History, not covered above:

Patient Sign & Date:

Date: