

Have you missed time from work?  Yes  No

If Yes: Full time off work \_\_\_\_\_ to \_\_\_\_\_ to \_\_\_\_\_

Part time off work \_\_\_\_\_ to \_\_\_\_\_ to \_\_\_\_\_

**OTHERS SEEN FOR THIS INJURY**

DATE	DOCTOR/HOSPITAL	TREATMENT/TESTS	RESULTS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**DESCRIPTION OF SYMPTOMS**

Check symptoms apparent since the problem began.

- |  |   |  |  |                                       |
|--|---|--|--|---------------------------------------|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain/stiffness     | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Chest pain   |
| <input type="checkbox"/> Midback pain            | <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Tension             | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands          | <input type="checkbox"/> Cold sweats  |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Loss of smell        | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Cold feet           | <input type="checkbox"/> Anxious      |
| <input type="checkbox"/> Pain behind eyes        | <input type="checkbox"/> Loss of taste        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Other _____  |

What activities make condition WORSE? \_\_\_\_\_

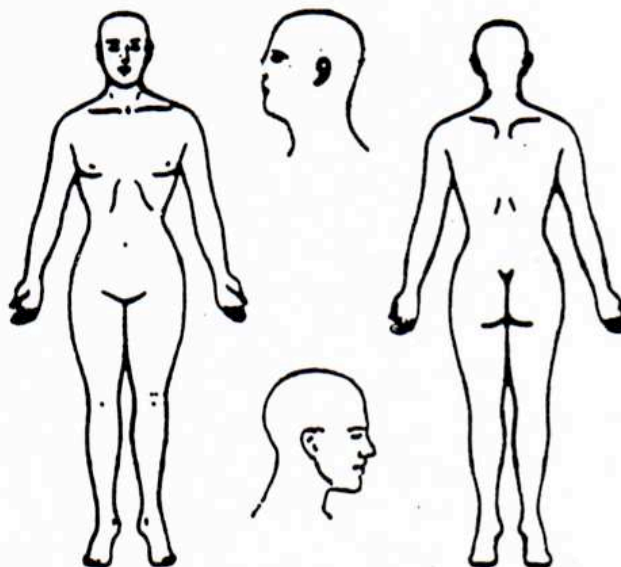
What activities make condition BETTER? \_\_\_\_\_

**INDICATE WHICH CAUSE PAIN**

- |   |  |
|---|--|
| <input type="checkbox"/> Coughing or sneezing           | <input type="checkbox"/> Climbing      |
| <input type="checkbox"/> Getting in or out of a car     | <input type="checkbox"/> Kneeling      |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Balancing     |
| <input type="checkbox"/> Turning over in bed            | <input type="checkbox"/> Dressing self |
| <input type="checkbox"/> Walking short distances        | <input type="checkbox"/> Sleeping      |
| <input type="checkbox"/> Standing for more than 1 hour  | <input type="checkbox"/> Stooping      |
| <input type="checkbox"/> Sitting at a table             | <input type="checkbox"/> Gripping      |
| <input type="checkbox"/> Lying on back                  | <input type="checkbox"/> Pushing       |
| <input type="checkbox"/> Lying flat on stomach          | <input type="checkbox"/> Pulling       |
| <input type="checkbox"/> Lying of side with knees bent  | <input type="checkbox"/> Reaching      |
| <input type="checkbox"/> Bending over forward           |  |

**SHADE AND CODE AREA(S) TO INDICATE LOCATION OF PAIN OR DISCOMFORT:**

USE CODES: P - PAIN N - NUMBNESS S - STIFFNESS



Symptoms are BETTER in:  AM  Midday  PM

Symptoms are WORSE in:  AM  Midday  PM

Symptoms do not change with time of day

Please rate your pain:

- Intermittent - When the symptoms or signs occur less than 25% of the time when awake.
- Occasional - When the symptoms or signs occur between 25% and 50% of the time when awake.
- Frequent - When the symptoms or signs occur between 50% and 75% of the time when awake.
- Constant - When symptoms and signs occur between 75% and 100% of the time when awake.

On a scale of 0 - 10, with 0 being (examiner's quote), "I'm pain free and can function quite well." and 10 being, "Very severe and cannot function at all." where would you rate yourself?

NORMAL      LOW PAIN      MODERATE PAIN      INTENSE PAIN      EMERGENCY  
 0            1 2 3            4 5 6            7 8 9            10

Relative to where you were before this injury, how would you rate how much you have recovered so far? \_\_\_\_\_ %