

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 ABILITY TO PERFORM THE FOLLOWING ACTIVITIES :

USE CODES : **U** - Unable **P** - Painful **D** - Difficult
L - Limited **N** - Normal

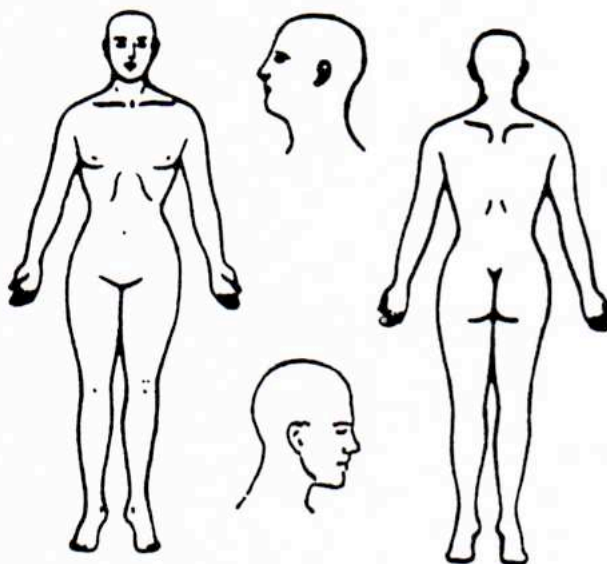
- | | |
|--------------------------------------|-----------------------|
| _____ Coughing or sneezing | _____ Climbing |
| _____ Getting in or out of a car | _____ Kneeling |
| _____ Bending forward to brush teeth | _____ Balancing |
| _____ Turning over in bed | _____ Dressing self |
| _____ Walking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

- Symptoms are **BETTER** in : AM Midday PM
 Symptoms are **WORSE** in : AM Midday PM
 Symptoms do not change with time of day

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

USE CODES :

P - Pain **N** - Numbness **S** - Spasm **T** - Tenderness :



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

Please explain why : _____

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