

**WHAT PROBLEM BRINGS YOU TO SEE US TODAY?**

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**WHEN DID THIS PROBLEM START?** \_\_\_\_\_

**WHAT CAUSED THE PROBLEM?** \_\_\_\_\_

If you were injured was it:

- At Home
- At Work
- Auto Accident
- Other personal injury

Did your pain come on:

- Suddenly
- Gradually

Is the pain:

- Constant
- On and off

Are you able to:

Sleep normally:  Yes  No

Do daily activities:  Yes  No

Care for yourself:  Yes  No

Function Normally:  Yes  No

Have you had this problem before:  Yes  No When? \_\_\_\_\_

Who treated your last occurrence? \_\_\_\_\_

On the figures at the right, please mark your area(s) of pain or discomfort using the following key:

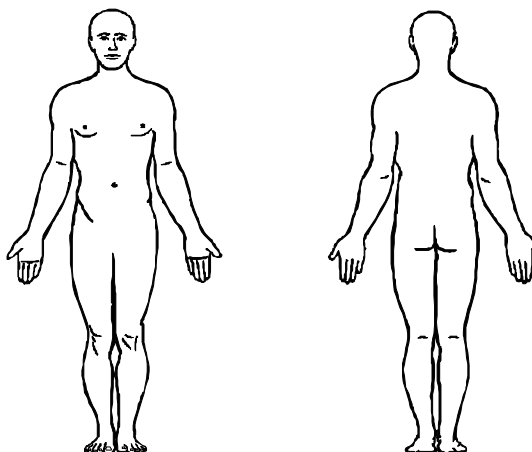
- +++ burning                      /// stabbing
- .... Pins & needles              XXX numb

Circle the areas (if more than one) of pain and Tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time:

Area 1 pain is \_\_\_\_\_/10

Area 2 pain is \_\_\_\_\_/10

Area 3 pain is \_\_\_\_\_/10



Which word describes your pain MOST of the time?

- Constant
- On and off
- Occasional
- Only at night
- Only on exertion
- Dull ache
- Tingling
- Burning
- Throbbing
- Deep, stabbing
- Deep, achy
- Sharp recurring

How would you describe your current mobility?

- Self mobile
- Need cane
- Need Walker
- Need wheelchair

Which best describes your current employment?

- Working
- Unemployed
- On sick leave
- On temporary disability
- On permanent disability
- Retired
- Full time
- Part time

If on disability, last full day of work

was: \_\_\_\_\_