Patient Basic Information

Personal Information:

Last Name:		First Name:	Mid. Init.:
Address:		City, State, Zip:	
Home Phone:	Work Phone:		Social Security No.:
Date of Birth:		Date of Injury/Onset:	
Dominant Hand: ❑ Right		❑ Left ❑ Both	
Insurance Information: Policy Holder (if different than patient):			Policy No.:

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

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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

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other________

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other________

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other________

4. Time/Speed/Damage

Time of accident________
Your vehicle's speed: ________mph
Their vehicle's speed: ________mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: Yes☐ ☐ No
Were you braced for the impact? Yes☐ ☐ No
Did you have a seat belt on? Yes☐ ☐ No
Did you have a shoulder harness on? Yes☐ ☐ No

Does your vehicle have headrests? Yes☐ ☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? **Yes☐ ☐ No** Did passenger side airbags deploy? **Yes☐ ☐ No** Did side airbags deploy? **Yes☐ ☐ 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:

Did your body strike the inside of your vehicle? **Yes☐ ☐ No**
If yes, describe:________
Did you lose consciousness during the injury? **Yes☐ ☐ No**
If yes, for how long?________
Your vehicle's estimated damage?________
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? **Yes☐ ☐ No**
Was an accident report filled out? **Yes☐ ☐ No**

10. After the accident:

Check off your symptoms right after and a few days following:
☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Cold hands
☐ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet
☐ Neck stiffnes ☐ Confusion ☐ Nervousness ☐ Diarrhea
☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression
☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious
☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems
Others:________

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐☐No **Was lab work done?** Yes☐☐No
Body parts X-rayed?________
What lab work?________
The X-rays revealed:________
Treatments: ☐ Cervical Collar ☐ Ice **Other:**________
Medications:________
Follow-up instructions:________
____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. ________ First visit date: ___/___/___
Specialty:________ X-rays done? **Yes☐☐No**
Types of treatments received:________
How many treatments received? ____ Currently treating? **Yes☐☐No**
Did treatments benefit you? **Yes☐☐ No**
Last visit date: ___/___/___
2. Dr. ________ First visit date: ___/___/___
Types of treatments received:________
How many treatments received? ____ Currently treating: **Yes☐☐No**
Did treatments benefit you? **Yes☐☐ No**
Last visit date: ___/___/___

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Description of Symptoms

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

I. First Current Symptom:

(Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________	☐	☐	☐
____________	☐	☐	☐

II. Second Current Symptom:

(Please check off the boxes below to describe your next symptom).

1. Check only one body location below

	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________	☐	☐	☐
____________	☐	☐	☐

III. Third Current Symptom:

(Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________	☐	☐	☐
____________	☐	☐	☐

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Description of Symptoms

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

IV. Fourth Symptom:

(Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________	☐	☐	☐
	☐	☐	☐

V. Fifth Current Symptom:

(Please check off the boxes below to describe your 5th symptom).

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________	☐	☐	☐
	☐	☐	☐

VI. Sixth Current Symptom:

(Please check off the boxes below to describe your 6th symptom).

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________	☐	☐	☐
	☐	☐	☐

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Description of Symptoms

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

VII. Seventh Symptom:

(Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________________	☐	☐	☐
	☐	☐	☐

VIII. Eighth Current Symptom:

(Please check off the boxes below to describe your 8th symptom).

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________________	☐	☐	☐
	☐	☐	☐

IX. Ninth Current Symptom:

(Please check off the boxes below to describe your 9th symptom).

1. Check only one body location below

Location	L	R	B
☐ Headaches	☐	☐	☐
☐ Front of Head			
☐ Top of Head			
☐ Back of Head			
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

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 your daily activites)

☐ 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:			
____________________	☐	☐	☐
	☐	☐	☐

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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 .... ___ Sitting for long periods....... ___ Walking 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 ...... ___ Exercising arms .... ___
Carrying large purse .... ___ Climbing inclines .... ___ 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

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but have not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ❑ 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 most recent prior similar symptoms (**if applicable**) occured.........___ ❑ months ago / ❑ years ago **Or on** Date:___/___/___

Write in below any other Prior Symptom History, not covered above:

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