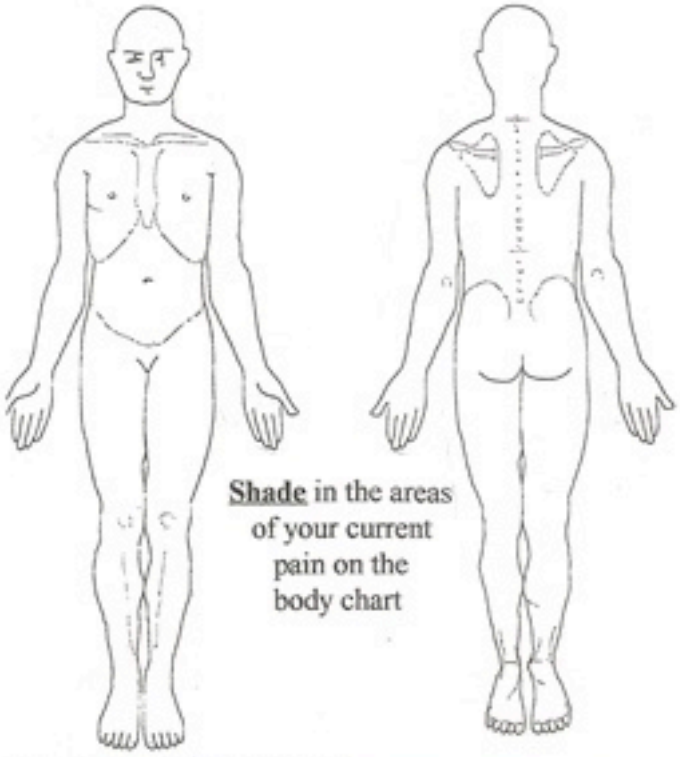

Shade in the areas of your current pain on the body chart

Name _____

Date _____

Please indicate how much pain you feel at this time by circling a number on the scale below

I___I___I___I___I___I___I___I___I___I___I
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

What are your symptoms? _____

Was the onset of this episode gradual or sudden? (check one)

o (A) Gradual o (B) Sudden

When did you first notice this episode of symptoms (specific date is possible)? _____

Which of the following best describes how your injury occurred? (check one)

o (A) lifting
o (B) a car accident
o (C) a fall
o (D) cumulative trauma (overuse)
o (E) trauma
o (F) degenerative process
o (G) during recreation sports
o (H) running
o (I) a blow to the face
o (J) being hit by a ball
o (K) a dental appointment.
o (L) throwing
o (M) unknown
o (N) other: _____

Since onset of this episode, are your symptoms getting: (check one)

o (A) better o (B) worse o (C) not changing

Nature of Pain: (check all that apply)

o (A) sharp
o (B) dull
o (C) throbbing
o (D) aching
o (E) period
o (F) occasional
o (G) constant
o (H) other: _____

Does the pain wake you at night?

o (A) no

If "yes", is it present:

o (A) while lying still o (B) only when changing positions o (C) both

Do you have pain/stiffness upon getting out of bed in the morning?

o (A) yes o (B) no

As the day progresses, do your symptoms: (check one)

o (A) increase o (B) decrease o (C) not change

What aggravates your symptoms? (check all that apply)

- o (A) sitting
- o (B) going to/rising from sitting
- o (C) standing
- o (D) squatting
- o (E) lying
- o (F) sleeping
- o (G) walking
- o (H) up/down stairs
- o (I) sustained bending
- o (J) looking up overhead
- o (K) reaching overhead
- o (K) reaching out from body
- o (K) reaching behind back
- o (K) reaching across body
- o (L) repetitive activities including _____
- o (M) recreation/sports including _____
- o (N) household activities including _____
- o (O) coughing/sneezing
- o (P) taking a deep breath
- o (Q) talking
- o (Q) yawning
- o (Q) chewing
- o (*) swallowing
- o (S) stress
- o (T) other: _____ _____

What relieves your symptoms? (check all that apply)

- o (A) sitting
- o (B) rising from sitting
- o (C) standing
- o (D) lying
- o (E) walking
- o (F) stretching
- o (G) exercise
- o (H) recreation/sports including _____
- o (I) rest
- o (J) cold
- o (K) heat
- o (L) massage
- o (M) traction
- o (N) alcohol
- o (O) whirlpool
- o (P) medication
- o (Q) nothing
- o (*) other: _____ _____

What previous treatment have you had? (check all that apply)

- o (A) none
- o (B) oral medication
- o (C) physical therapy
- o (D) joint manipulation by a chiropractor or osteopath
- o (E) massage therapy
- o (F) exercise
- o (G) bracing/taping
- o (H) traction
- o (I) injection into the spine
- o (J) injection into the skin/muscles
- o (K) **SURGERY** (on this body region)
- o (L) hypnosis
- o (M) Biofeedback
- o (N) TENS unit
- o (O) acupuncture _____
- o (P) bed rest
- o (Q) overnight hospitalization
- o (*) other: _____ _____

****DATE OF SURGERY TO THIS BODY REGION IF ANY:** _____

****TYPE OF SURGERY TO THIS BODY REGION IF ANY:** _____

Have you had any of the following:

- o (B) x-rays
- o (C) CT scan
- o (D) MRI
- o (E) arthrogram
- o (F) stress x-ray test (telos)
- o (G) other: _____

Do you have any of the following? (If you answer yes to any of the following questions please explain)

	YES	NO	EXPLANATION
High blood pressure	o	o	_____
Heart Disease	o	o	_____
Pacemaker	o	o	_____
Diabetes	o	o	_____
Respiratory Problems	o	o	_____
Cancer	o	o	_____
Broken Bones	o	o	_____
Are you pregnant?	o	o	_____
Have you had any surgeries?	o	o	_____
Are you on any medication?	o	o	_____

Patient Signature: _____ **Therapist Signature:** _____