Reason for Visit Today

Initial Exam ( ) Update ( ) Progress ( ) Final Exam ( )

Main Complaint:_____ Left /Right/Both

Pain Severity (please circle) Least Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Injury? What happened?_____

_____

When did it Start ? Sudden / Gradual / Cumlative / Chronic / Unsure

How long has this been going on?_____

Course: Progressively getting worse / Getting Better / Staying Same

Definition of Pain:

Minimal:	Pain present but forgotten with activity
Mild:	Annoying but does not interfere with activity
Moderate:	Pain Requires modification of activity but not disabling
Severe:	You are unable to perform normal duties due to pain
Very Severe:	Causes you to cry out in Pain

Past history of this condition? Yes / No / Unsure Explain:_____

What % (please circle: 10, 20, 30, 40, 50, 60, 70, 80, 90, 100) of the (Day / Week / Year) does it bother you?

How often (Min. / Hours) during the (Day / Week / Year) does it bother you?

When you are in pain, how long does it last? (Min. / Hours / Days)

Does it feel (better) or (worse) in the (Early Morning / Morning / Afternoon Evening / Late Night/ Wake you from sleep) ?

Describe how this complaint feels: (circle all that apply) Sharp / Dull / Throbbing / Burning / Deep / Aching / Tingling / Stabbing / Cramping / Numbness / Radiating . If radiating where? Down the (arm / leg / back / etc.): _____Right side / Left side / Both

Pain aggravated worse by: (circle all that apply) Sitting / Standing / Sneezing / Coughing / Straining / Reaching / Looking up / Looking down/

Movement / Rest / Driving / Typing / Household Chores / Exercise / Stairs / Twisting / Using computer /

Pain relieved by : (circle all that apply) Sitting / Standing / Lying down / Knees Bent / Support / Movement / Heat / Ice / Rest / Ibuprofen/ Analgesic topical ointment/ Streching / Exercise / Adjustments / No movement