

Date: \_\_\_\_\_ Company: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Occupation/Job: \_\_\_\_\_ # Yrs \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING:**

Since your last visit how are you?  Better  Same  Worse

Rate your pain level (0=no pain, 10=worst pain) 0 1 2 3 4 5 6 7 8 9 10

Rate your current level of activity (0=inactive, 10=regular activities) 0 1 2 3 4 5 6 7 8 9 10

Are you working:  Light duty  Regular duty  Not working

What makes your pain worse?  
 Bending  Rising from sitting  Walking  Lying down  Coughing  Sneezing  Other \_\_\_\_\_

What makes your pain better?  
 Heat  Ice  Standing  Walking  Lying down  Not Working  Other \_\_\_\_\_

Do you have any difficulty sleeping because of your pain?  No  Yes \_\_\_\_\_

Have you had any problems with your stomach or bowel habits since your injury?  No  Yes \_\_\_\_\_

Have you had any changes in urination (e.g. difficulty starting, stopping or controlling)?  No  Yes \_\_\_\_\_

Do you have any weakness in your legs / arms?  No  Yes \_\_\_\_\_

What medications are you taking for this problem? \_\_\_\_\_

Have you had problems with your medication?  No  Yes \_\_\_\_\_

Are you going to physical therapy or chiropractor?  No  Yes \_\_\_\_\_

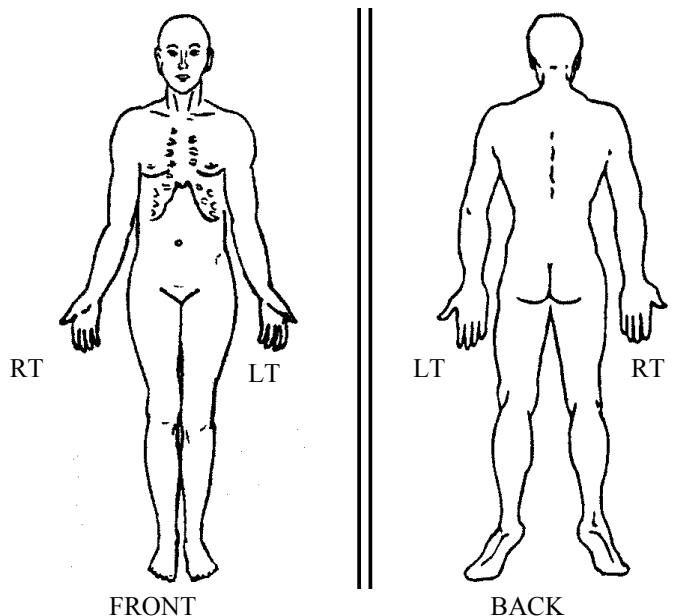
Are you performing home exercises?  Daily  Every other day  Occasionally  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Using the symbols below, please mark the areas on the diagram where you feel sensations.  
 Please be sure to indicate all areas affected by the sensations.

Sore or painful <b>XXXX</b>
Numbness/Tingling <b>000000</b>
Burning <b>/////</b>

Are these sensations:  
 Intermittent  
 Constant



X  
 \_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date