Patient Name:_____Date:_____

Please answer the following to the best of your knowledge. This information will help us to thoroughly address your condition and prescribe what is best for you.

About your condition…

What type of pain/discomfort are you **currently having?**

Headaches Neck R / L Shoulder R / L Wrist
Mid Back (Between Shoulder Blades) Low Back R / L Knee R / L Ankle
Other _____

Are there any other injuries that currently concern you?

Headaches Neck R / L Shoulder R / L Wrist
Mid Back (Between Shoulder Blades) Low Back R / L Knee R / L Ankle
Other _____

When did the pain start? (Circle One)

Immediately Hours Later That Night Next Day Other _____

Does anything make the pain feel better? Yes No (Circle all that apply)

Rest Ice Heat Medication (type) _____ (prescribed or over the counter)
Other_____

What makes the pain feel worse? (Circle all that apply)

Work Walking Bending Lifting Sitting Lying down Other_____

Which of the following best describes your pain? (Circle all that apply)

Achy Dull Sore Sharp Stabbing Spasm
Shock-like Tingling Numbness Weakness Stiffness
Restricting Throbbing Other_____

Do you have any pain radiating into your arms or legs? Yes No

If yes, please describe_____

When is your pain the worst? (Circle One)

Mornings Afternoon Evenings Throughout the Day

How often do you have the pain/discomfort?

Constant (75-100%) Frequent (50-75%) Intermittent (25-50%) Occasional (0-25%)

How is your pain since it first began?

Getting Better Getting Worse Staying the same

Have you noticed any activity restrictions as a result of this injury (such as difficulty sleeping, work restrictions, difficulty doing household activities, difficulty taking care of self and family, and/or difficulty or inability to exercise)? Yes No
If Yes, please describe: _____
_____
_____

Signature:_____