

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Are you pregnant?  Yes  No  N/A

Major complaints — please be specific in describing what brings you in today: \_\_\_\_\_

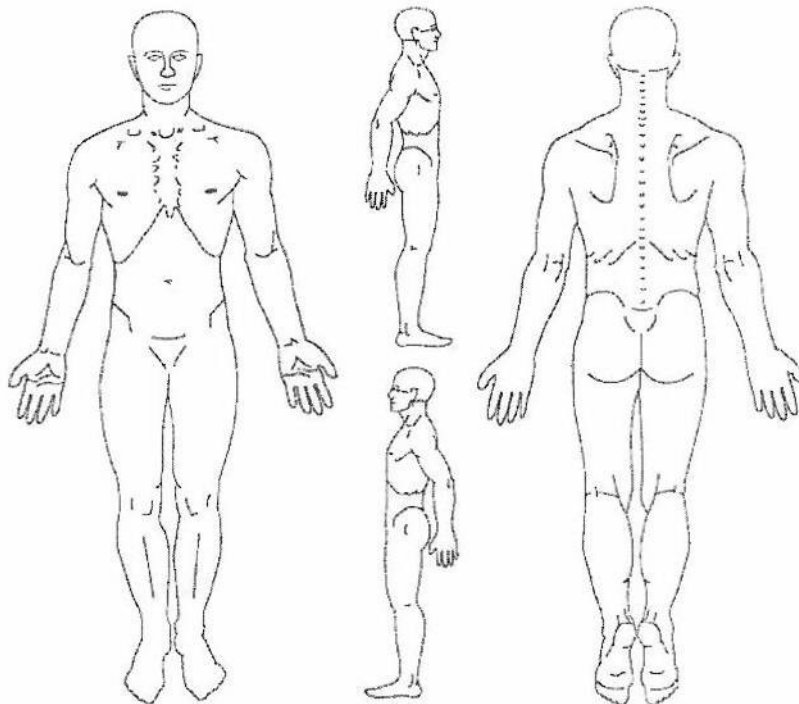
When did you first notice this problem/pain? \_\_\_\_\_

How do you believe this problem/pain began? \_\_\_\_\_

During the course of the day how often do you experience your symptoms?

Intermittently 0-25%  Occasionally 26-50%  Frequently 51-75%  Constantly 76-100%

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating, from 0-10, how much pain are you experiencing?

(0 = no pain and 10 = the worst pain imaginable)

Please circle the pain level over the last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Please circle the pain avg. level over the last week: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: \_\_\_\_\_

Are your symptoms a result of:  Motor Vehicle Accident  Work related Accident  Other \_\_\_\_\_

How much have your symptoms changed?  Getting Better  Getting Worse  Not Changing

In general, my overall health is...  Excellent  Very good  Good  Fair  Poor