Patient Name ______________________________ **Date** ______________

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Major complaints - please be specific in describing what brings you in today: ______________________________

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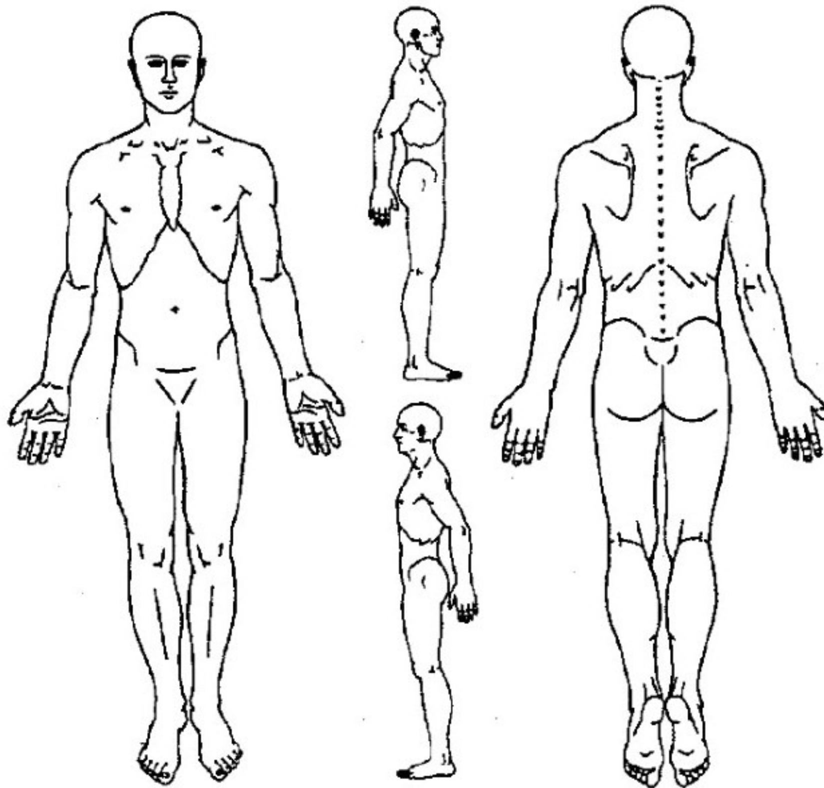
When did you first notice this problem/pain? ______________________________

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 average 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: ______________________________

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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