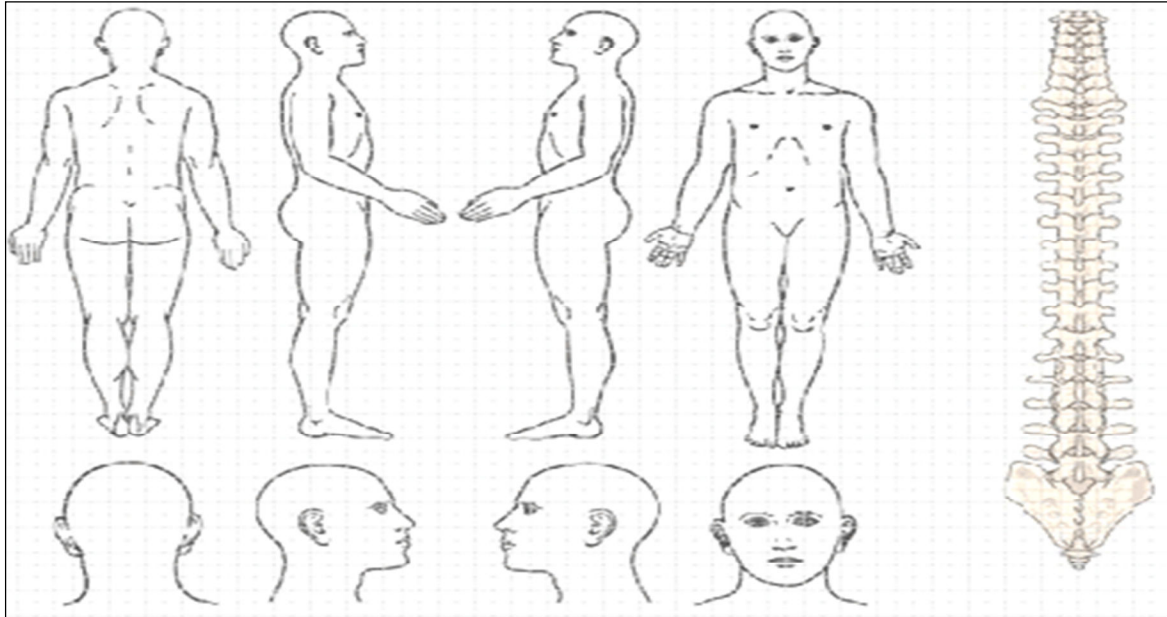


Patient Symptoms Report & Diagram

Name: _____ DOB: _____ Date: ___/___/___

Mark these drawings according to where you hurt (ex: if the back of your neck has pain, circle the back of the neck, etc.). If you feel any symptoms, please indicate where you feel them by placing marks on the diagram. Include all affected areas.



Please circle the appropriate number below showing how bad your pain is now:

Now:	No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain
At Worst:	No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain
At Best:	No pain	1	2	3	4	5	6	7	8	9	10	Worst possible pain

1. What is the purpose of Today's Evaluation? _____.

2. Are you still working? Yes No if not when was the last day on the Job? _____.

3. Occupation: _____.

4. When (roughly what date) did your present pain start? _____.

5. How did symptoms start? (Check appropriate box)

- No apparent cause Gradually Twisting Bending
 Lifting Fall Pulling /Pushing Suddenly

<input type="checkbox"/> Injured during work Date: ___/___/___	<input type="checkbox"/> Injured in auto accident Date: ___/___/___	<input type="checkbox"/> Injured at sports Date: ___/___/___
-------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

6. Have you had similar pain? Yes No Date ___/___/___

7. Have you been hospitalized for your pain problem? Yes No Date ___/___/___

8. How do you describe your pain? Constant Intermittent

9. What describes the nature of your symptoms?

- Sharp Shooting Burning
 Dull ache Numb Tingling

10. What activities make the pain worse/ Better/No difference?

	Better	Worse	No Difference	Comments
<input type="checkbox"/> Exercise				<input type="checkbox"/> During <input type="checkbox"/> After
<input type="checkbox"/> Lying down				<input type="checkbox"/> supine <input type="checkbox"/> right side <input type="checkbox"/> left side
<input type="checkbox"/> Sitting				<input type="checkbox"/> How long
<input type="checkbox"/> Standing				<input type="checkbox"/> How long
<input type="checkbox"/> Walking				<input type="checkbox"/> Distance
<input type="checkbox"/> Bending				<input type="checkbox"/> forward / backward <input type="checkbox"/> right side <input type="checkbox"/> left side
<input type="checkbox"/> Overhead activities				
<input type="checkbox"/> Lifting / pushing / pulling				
<input type="checkbox"/> Coughing / Sneezing				
<input type="checkbox"/> Pain Medications				
<input type="checkbox"/> Other				

11. What medications are you currently taking? (If additional space is needed please use the back of this sheet)

12. Have you received any of the following tests?

Date:

- | | | |
|--------------------------------------------|-----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Diagnostic x-rays | <input type="checkbox"/> CT (computed tomography) scan | <input type="checkbox"/> Electromyogram (EMG) |
| <input type="checkbox"/> Discogram | <input type="checkbox"/> MRI (magnetic resonance imaging) | <input type="checkbox"/> Others _____ |

13. In general would you say your overall health right now is...

- Excellent Very good Good Fair Poor

14. Medical history (Circle Yes or No)

Allergies	Y / N	Currently Pregnant	Y / N	Kidney Problems	Y / N
Anemia	Y / N	Depression	Y / N	Metal Implants	Y / N
Anxiety	Y / N	Diabetes	Y / N	Multiple Sclerosis	Y / N
Arthritis	Y / N	Dizzy Spells	Y / N	Osteoporosis	Y / N
Asthma	Y / N	Emphysema/Bronchitis	Y / N	Parkinsons	Y / N
Cancer	Y / N	Fractures	Y / N	Rheumatoid Arthritis	Y / N
Cardiac Conditions	Y / N	Gallbladder problems	Y / N	Seizures	Y / N
Cardiac Pacemaker	Y / N	Hepatitis	Y / N	Speech Problems	Y / N
Chemical Dependency	Y / N	High Blood Pressure	Y / N	Strokes	Y / N
Circulation Problems	Y / N	Incontinence	Y / N	Thyroid Disease	Y / N
Tuberculosis	Y / N	Vision Problems	Y / N	Other:	

15. Fall History:

- Injury as a result of fall in the past year: Yes / No When: _____.
- Two or more falls in the past year: Yes / No When: _____.

16. Surgical History: (If additional space is needed please use the back of this sheet)

- Date: ____ / ____ / ____ Body region: _____.
- Surgery type: _____.

17. Do you have any additional information that would be helpful in understanding your problem?

Patient signature: _____ Date: _____