DOB: _____

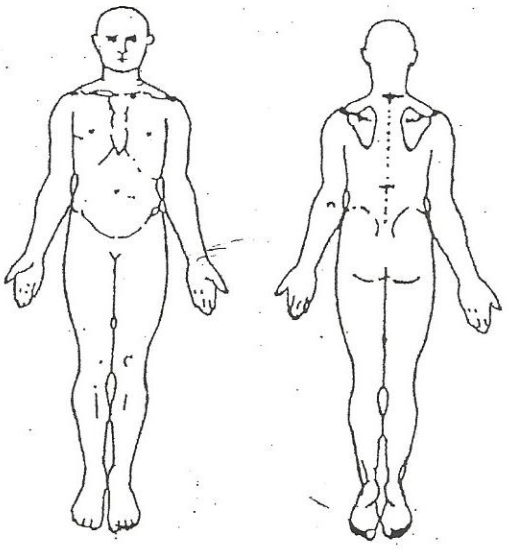
Name:_____ **Date:**_____

Injury Area:_____

*** Please answer each question as accurately as possible. This form will assist the therapist with your evaluation!**

I. Present Status:

1. When did the pain start?_____
2. How bad is the pain on a scale of 1-10, 10 being the worst. Please circle below.
   1 - - - - 5 - - - - - 10
3. Where is the pain now? (Circle the area on the chart)
4. Did the pain spread? _____
5. Do you have any pins and needles, tingling feelings or numbness?
   _____No _____Yes: Where:_____
6. What activities or movements makes the pain worse?
   _____
7. What eases your pain, (i.e. ice, massage?) _____
8. Can you get comfortable at night? _____No _____Yes
9. How do you feel when you wake up?
   _____Stiff _____Sore _____Fine
10. Once you start moving about does the pain
    _____ Worsen _____ Ease _____ Remain the same
11. What is the pain like at the end of the day?
    _____ Worse _____ Better _____ The same
12. Does coughing or sneezing affect you pain? _____ No _____ Yes
13. What is your least comfortable position?_____
    What is the most comfortable position? _____
14. Have you had headaches since this injury/onset? _____ No _____ Yes
15. Have you received any treatment(s) for this current problem? _____ No _____ Yes
    If you checked yes, please describe:_____ Did the treatment(s) help? _____ No _____ Yes
16. Are you presently taking medications for this problem? _____ No _____ Yes
17. At the present time, do you think you are getting _____ Better _____ Worse _____ The Same
18. What test(s) have you had? (x-ray, CAT scan, MRI):_____



- Are you currently working? _____ No _____ Yes If you chose yes, type of work_____
- Limited work level_____

II. Previous History

- Prior to this injury/onset were you completely free of symptoms? _____Yes _____No
- Had you ever had anything similar to this injury/onset? _____No _____Yes
  If you answered yes, please describe and answer the following questions :_____
  Are your symptoms becoming more frequent? _____No _____Yes
  Are your symptoms becoming more severe? _____No _____Yes
  Are your symptoms changing/different?_____No _____Yes Describe:_____
  What usually causes these episodes? _____
  Were you hospitalized for your injury? _____No _____Yes
- Is there anything else that you think your therapist should know? (i.e. other medical problems):

_____

_____

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See back of form