Name _____ Date _____

REASON FOR VISIT - Chief complaint

_____NECK PAIN ____ UPPER BACK /MID BACK PAIN ____ LOW BACK PAIN

_____HIP PAIN ____ SHOULDER PAIN -RIGHT LEFT _____ FOOT PAIN- RIGHT LEFT

_____ARM/ SHOULDER /WRIST PAIN _____ JAW PAIN _____ LEG PAIN
_____OTHER
EXPLAIN_____
_____
_____

ONSET DATE _____

WHAT MAKES YOUR PAIN WORSE - circle all that apply

BENDING , LIFTING , MOVING NECK OR BACK , LIFTING ARMS OVERHEAD
COUGHING, SLEEPING , LOOKING UP OR DOWN , GETTING IN AND OUT OF CAR
DRIVING, COMPUTER WORK , SITTING , TRAVELING , LIFTING /CARRYING THINGS
WORKING OUT/ EXERCISING, WALKING , WALKING UP STAIRS /DOWN STAIRS
Other _____

WHAT MAKES YOUR PAIN BETTER

REST, ICE , HEAT, NSAIDS PAIN RELIEVERS , CREAMS OR MUSCLE GELS OR PATCHES
NOT MOVING, LYING DOWN , STANDING , SITTING , NOTHING

WHAT DOES YOUR PAIN FEEL LIKE

DULL____ACHY____ SHARP___ STABBING___ BURNING ____
OTHER _____

DOES YOUR PAIN TRAVEL TO ANY OTHER AREAS_____ IF SO WHERE
_____

HOW WOULD YOU RATE YOUR PAIN - MILD_____MODERATE_____ SEVERE_____

RATE YOUR PAIN — NO PAIN = (0) 1 2 3 4 5 6 7 8 9 (10) = WORST PAIN EVER

IS YOUR PAIN— CONSTANT———ON AND OFF
HAVE YOU HAD THIS ISSUE BEFORE YES _____NO_____

PRIOR CAR ACCIDENT YES _____ NO_____
PRIOR INJURIES /SPORTS INJURIES YES _____ NO_____