

Please complete this section regarding your current condition. Your careful answers will help us to understand your problem and design the best treatment program for you.

CHARACTERISTICS OF PAIN:

How long have you had your current problem?

_____ weeks _____ months _____ years

Below, **CIRCLE THE #1 PROBLEM** for which you are seeking treatment.

- | | |
|--|--|
| Low back or buttock pain
Right leg pain Left leg pain
Pain in both legs
Right leg numbness Left leg numbness
Numbness in both legs
Difficulty walking | Neck pain Right arm pain
Left arm pain
Pain in both arms Right arm numbness
Left arm numbness Numbness in both arms
Other: _____ |
|--|--|

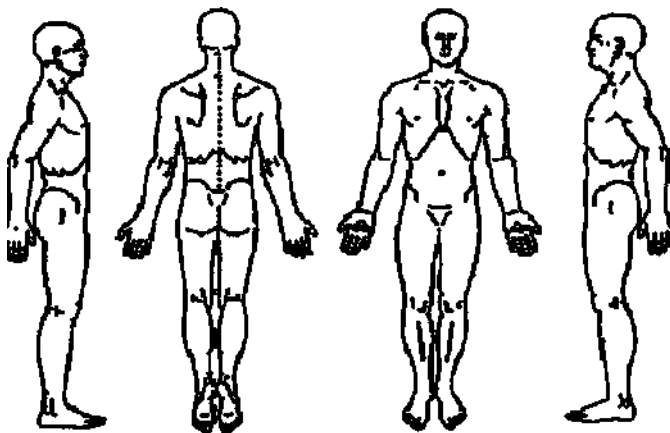
Above, **UNDERLINE THE #2 PROBLEM** for which you are seeking treatment.

Other problems (please describe): _____

WHERE IS YOUR PAIN NOW?

On the diagram below, place an X in the area(s) you feel the most pain. Place an O on the body diagram where you feel numbness or tingling.

Right Back Front Left



PAIN IS BEST DESCRIBED AS:

- Dull ache
- Sharp
- Burning
- Electric shock

ONSET OF PAIN: How did your current symptoms start?

- Injury at work _____ date of injury, at work
- Injury, not at work _____ date of injury, not at work
- Motor vehicle accident _____ date of accident
- Undetermined
- Other: _____

SEVERITY OF PAIN: In general, what is the intensity of your pain (*circle one*)?

No Pain 01 2 3 4 5 6 7 8 9 10 **Worse Possible Pain**

In general, how is this problem affecting your life (please check one)?

- Nuisance
- Minor problem
- Major problem
- Catastrophe

TIMING OF PAIN: How often do you have your pain (please check one)?

- Occasionally (less than 30% of the time)
- Intermittently (30-60% of the time)
- Nearly constantly (60 to 95% of the time)
- Constantly (100% of the time)

RELIEVING AND AGGRAVATING FACTORS:

How do the following affect you pain (please check one for each item):

	IMPROVES PAIN	NO CHANGE	WORSENS PAIN
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
COUGHING/SNEEZING			
BOWEL MOVEMENTS			

Have you had any recent change in bowel or bladder habits?

- No 1
- Yes Please describe: _____

ACTIVITIES AND YOUR PAIN:

How many blocks can you walk?

- Less than a block
- 1-2 blocks
- 2-5 blocks
- 5-10 blocks
- Greater than 10 blocks

How often during the day do you lie down because of pain?

- Never
- Seldom
- Sometimes
- Often
- Constantly

To assist walking, I use a:

- Cane
- Walker
- Wheelchair
- No assistance device

I am NOT able to perform the following activities of daily living (check all that apply):

- Doing yard work or shopping
- Socializing with friends
- Performing household chores
- Participating in recreational activities
- Going to work
- Exercising

