



PLEASE DESCRIBE YOUR MAJOR COMPLAINT \_\_\_\_\_

How did it begin \_\_\_\_\_

When did it begin \_\_\_\_\_

PLEASE **CIRCLE** THE NATURE & INTENSITY OF YOUR PAIN

SHARP      NUMBNESS      TINGLING      DULL ACHE      SHOOTING      THROBBING      BURNING  
CONSTANT (76-100%)      FREQUENT (51-75%)      OCCASIONAL (26-50%)      INTERMITTENT (24%ORLESS)

INTENSITY OF YOUR PAIN AT REST      (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

INTENSITY OF YOUR PAIN WITH MOVEMENT      (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

SINCE THIS CONDITION BEGAN YOUR SYMPTOMS HAVE: \_\_\_ DECREASED \_\_\_ NOT CHANGED \_\_\_ INCREASED

WHAT ACTIVITIES MAKE PAIN: Better \_\_\_\_\_

Worse \_\_\_\_\_

YOUR SYMPTOMS ARE WORSE IN THE: \_\_\_\_\_ MORNING      \_\_\_\_\_ AFTERNOON      \_\_\_\_\_ NIGHT

IN THE PAST, HAVE YOU BEEN TREATED FOR THIS SAME PROBLEM? \_\_\_\_\_ YES      \_\_\_\_\_ NO

IF YES, WHO DID YOU SEE FOR THIS CONDITION      \_\_\_\_\_ MD      \_\_\_\_\_ PHYSICAL THERAPIST

\_\_\_\_\_ OCCUPATIONAL THERAPIST      \_\_\_\_\_ CHIROPRACTOR      \_\_\_\_\_ OTHER

IF YES, WHAT TREATMENT DID YOU RECEIVE? \_\_\_\_\_

OCCUPATION \_\_\_\_\_ HAS YOUR WORK STATUS CHANGED BECAUSE OF THIS      \_\_\_ YES      \_\_\_ NO

DO YOU EXERCISE: YES \_\_\_ NO \_\_\_      AMOUNT: WK \_\_\_\_\_ DAY \_\_\_\_\_      HEIGHT: \_\_\_ ft. \_\_\_ in.      WEIGHT: \_\_\_\_\_ #

DO YOU FEEL YOU WEIGHT CONTRIBUTES TO YOUR PROBLEM: YES \_\_\_ NO \_\_\_

Please mark as follows on the drawings:

- B - burning
- P - pain
- N - numbness
- C - cold
- T - tingling

