REASON FOR VISIT

Patient Name _____ Date _____

REASON FOR THIS VISIT: _____

Is this condition related to an injury while at work <u>OR</u> an automobile accident? _____Yes _____No

Date symptoms began: _____

How did it occur? Is there anything that contributed to the onset of the complaint? _____
_____
_____
_____

Is this condition getting progressively worse? ___Y ___N

Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain) _____

Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting ___Burning

___Tingling ___Cramps ___Stiffness ___Swelling ___Other

How often do you have this pain? ___Constant ___ Intermittently

Does it interfere with your: ____Work? ___Sleep? ___Daily Routine? ___Recreation?

Activities or movements that are painful to perform: ___Sitting ___Standing ___Walking ___Bending ___Lying Down

On the diagram below, please indicate, by marking an "X", where you are experiencing pain.