Patient Basic Information

Personal Information:

Last Name:			First Name:			Mid. Init.:	
Address:			City, State, Zip:				
Home Phone: Work P		hone:		Social Security No.:			
Date of Birth:		Date of Injury/On	set:				
Dominant Hand:	oominant Hand: 🛛 Right		Left	Both			
Insurance Information: Policy Holder (if different than patient):					Policy No.:		

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Patient Sign & Date:___

1

Automobile Accident Description

1. Your vehicle type	2. Your position in vehicle	3. What	was your vehicle de	oing at the time of th	e accident?			
Car Station Wagon Van Pickup Truck Large Truck Bus Other	 Driver Front Passenger Left Rear Passenger Right Rear Passenger Other 		ed at intersection ng a right turn eding along	n Stopped in traffic Stopped at lig Making a left turn Parking Slowing down Accelerating				
4. Time/Speed/Damage	5. Details of Accident	6. Road	6. Road conditions					
Time of accident Your vehicle's speed:mph Their vehicle's speed:mph Damage to your vehicle Mild Moderate Totaled	Visibility at time of accident Poor Fair Good Who hit who/what? You hit other vehicle Other vehicle hit you You hit(object)	Road co lcy Point of Head Rear-	impact -On		ean and dry Right Front Right Rear			
7. Body Position, etc.		-						
Did you see the accident coming Were you braced for the impact Did you have a seat belt on? Did you have a shoulder harnes Did driver side air bags deploy? 8. Additional accident inform In the case of a motor vehicle a	? Yes I No Yes I No is on? Yes I No Yes I No Yes I No Did passenger sination	at was the Even with to at was the Facing stra airbags dep	position of your op of head Deven direction of your ight forward D Tur oloy? Yes D No		Middle of neck Middle of neck of the impact? Turned to the left Moy? Yes No			
9. During the accident:		10. Afte	er the accident:					
Did your body strike the inside of If yes, describe: Did you lose consciousness durin If yes, for how long? Your vehicle's estimated damage? Damage to their vehicle: Did police show up at th Was an accident report	g the injury? Yes No	Heac Neck Neck Fainti Ringi Loss	lache Dizzine pain Nausea stiffness Confus ng Fatigue ng in ears Tensior of smell Irritabilit behind eyes Sho	a Low back pa sion Nervousne Loss of taste	ain Cold hands ain Cold feet ss Diarrhea e Depression ess Anxious n Chest Pain leeping problems			
11. Emergency Room?			tment History:					
Where did you go after the accide Home Work Home How did you get there? Drove self Somebody else Were X-rays done? Yes Notestime Body parts X-rayed? What lab work? The X-rays revealed: Treatments: Cervical Collar Medications: Follow-up instructions:	Ambulance Private Doctor Ambulance Police Was lab work done? Yes	Fill in ar 1. Dr Specialty Types of How mar Did treat 2. Dr Types of How mar Did treat	treatments received: treatments received: ments benefit you? t date:/	/ First visit dat	te:// ? Yes I No ating? Yes I No e://			

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

Patient Sign & Date:_____

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_____ Date:_____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

	nt Symptor	n: (Pleas	e check	off the boxes below to describe your first symptom. Describe only ONE	sympt	om per	Section
1. Check only	one body loo	cation be	low	2. Types of pain		r types o	
Headaches		R 🗖	в 🗖	Dull Sharp Aching Cutting			
	Front of Head	i		Throbbing Burning Numbing Tingling Cramping			
	Top of Head			Spasm Stinging Shooting Pounding Constrictin	g		
□ □ □Jaw	Back of Head	R 🗖	в 🗖	3. Pain Frequency 6. Actions affecting	this pa	in	
			вЦ	DUp to 1/4 of awake time 1/4 to 1/2 of time Brin			Relieves
		R 🔲	в	\Box 1/2 to 3/4 of awake time \Box Most all the time \Box In the A.M.			
Upper Back		R 🗖	вО	4. Pain Intensity (How it affects your daily			H
Mid Back	L 🗖	R 🗖	в 🗖	activites) Bending forward Bending back			
Low Back		R 🔲	в 🛄	Doesn't affect Somewhat affects Bending back Seriously affects Prevents activities Bending left		H H	H
		R 🔲	вЦ		ā		
□Abdomen □Ribs		R 🗖 R 🗖	в 🗖 в 🗖	Jother Bight Both			
Buttocks			вО				
		R 🗖	в			H	H
	īū	R 🗖	в 🗖	Shoulder Image: Constraining Arm Image: Constraining			
Forearm		r 🗖	в 🗖			H	
Hand		R 🔲	В		ā		
Hip		R	ВП	Leg Image: Constraint of the second			
□Leg □Foot		R 🗖 R 🗖	в 🗖 в 🗖	Foot Other Actions:			
				Other locations of radiation:			
		ntom-					
II. Second Cu 1. Check only			Nole	(Please check off the boxes below to describe your next symptom). 2. Types of pain	Other	r types o	of nain.
			вЦ		Other	types t	n pam.
	Front of Head			Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping			
	Top of Head			Spasm Stinging Shooting Pounding Constriction			
	Back of Head			3. Pain Frequency 6. Actions affecting		in	
Jaw		R	вЦ	Up to 1/4 of awake time 1/4 to 1/2 of time Brin	-	ggravates	Relieves
□Eye □Neck	L 🔲 L 🖵	R 🗖 R 🗖	в 🗖 в 🗖	\Box 1/2 to 3/4 of awake time \Box Most all the time \Box In the A.M.			
Upper Back			вЦ	4. Pain Intensity (How it affects your daily			
Mid Back	ī 🗖	RŪ	в 🗖	activites) Doesn't affect Somewhat affects Bending back			
Low Back	L 🗖	R 🗖	в 🗖	□ Doesn't affect □ Somewhat affects □ Bending back □ Seriously affects □ Prevents activities □ Bending left			
Chest	L 🖸	R 🔲	в 🔲	5. Does this pain radiate into other body parts?	ā		
		R 🔲	вЦ	Left Right Both Disting left			
□Ribs □Buttocks	L 🔲 L 🖵	R 🗖 R 🗖	в 🔲 в 🗖	Head D D D Twisting right			
			вЦ	Neck Image: Coughing		L.	H
Upper Arm	ī 🗖	R	в 🗖	Shoulder Image: Constraining Arm Image: Constraining			
Forearm	L 🗖	R 🗖	в 🗖	Hand	Ľ	Н	H I
Hand	L	R 🛄	в 🔲		ā		
Hip		R	ВЦ				
Leg Foot	L 🔲 L 🖵	R 🗖 R 🗖	в 🔲 в 🗖	Foot Other Actions:	_	_	_
Other location				Other locations of radiation:			
			/_				
III. Third Curr 1. Check only of				Please check off the boxes below to describe your 3rd symptom). 2. Types of pain			fnoin
				L. IVICS VI VAIII	04 h c	tunce -	
	L	R 🔲			Othe	r types o	n pam.
	L D Front of Head	R 🗖	low в 🗖	Dull Sharp Aching Cutting	Other	r types o	л раш.
Headaches	L D Front of Head Top of Head	R 🗖		Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping		r types o	———
	L D Front of Head Top of Head Back of Head	R 🗖	в 🗖	Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping Spasm Stinging Shooting Pounding Constricting 3. Pain Frequency 6. Actions affecting	g		
Headaches F J J Jaw	L Front of Head Fop of Head Back of Head L	R 🗖 R 🗖	в 🖬	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ 01/4 of awake time □ 1/4 to 1/2 of time □ Brin	g this pa	iin .ggravates	Relieves
Headaches	L Front of Head Fop of Head Back of Head L L		В 🔲 В 🔲 В 🔲	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time 6. Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M.	g thispa gsOn A	iin .ggravates	Relieves
Headaches If Jaw Eye Neck	L Front of Head Top of Head Back of Head L L L L		В 🔾 В 🔲 В 🔲 В 🗍	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time 6. Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the P.M. 4. Pain Intensity (How it affects your daily □ In the P.M. □ In the P.M.	g thispa gsOn A	in ggravates	Relieves
Headaches	L Front of Head Fop of Head Back of Head L L L L L L L L	R 🗆 R 🗆 R 🗆 R 🗆 R 🗆	B 🔾 B 🔾 B 🔾 B 🔾 B 🔾 B	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constricting 3. Pain Frequency 6. Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. 4. Pain Intensity (How it affects your daily activites) □ In the P.M.	g this pa gs On A	in ggravates	Relieves
Headaches	L Front of Head Fop of Head Back of Head L L L L L L L L L L	R	B 🔾 B 🔾 B 🔾 B 🔾 B 🔾 B 🖓	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constricting 3. Pain Frequency 6. Actions affecting □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ In the A.M. □ 1/2 to 3/4 of awake time □ Most all the time □ In the P.M. activites) □ Doesn't affect □ Somewhat affects □ Bending forward	g this pa gs On A	iin ggravates	Relieves
Headaches	L Front of Head Top of Head Back of Head L L L L L L L L L L	R	B	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency 6. Actions affecting □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ In the A.M. □ 1/2 to 3/4 of awake time □ Most all the time □ In the P.M. □ Loesn't affect □ Somewhat affects □ Bending forward □ Doesn't affects □ Prevents activities □ Bending left 5. Does this pain radiate into other body parts? □ Bending right	g this pa js On A	in ggravates	Relieves
Headaches	L Front of Head Front of Head Back of Head L L L L L L L L L L	R 000000000000000000000000000000000000	B C C C C C C C C C C C C C C C C C C C	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency 6. Actions affecting □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ In the A.M. □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. 4. Pain Intensity (How it affects your daily activites) □ Doesn't affect □ Somewhat affects □ Doesn't affects □ Prevents activities □ Bending back 5. Does this pain radiate into other body parts? □ Bending right Left Right Both	g this pa gs On A Q	in ggravates Q Q Q Q Q Q Q Q	Relieves
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Headaches	L Front of Head Front of Head Back of Head L L L L L L L L L L	R R R R R R R R R R R R R R R R R R R	B C C C C C C C C C C C C C C C C C C C	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constricting 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ In the A.M. □ In the A.M. □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the P.M. ■ Loosn't affect □ Somewhat affects □ Bending forward □ Doesn't affects □ Prevents activities □ Bending torward 5. Does this pain radiate into other body parts? □ Bending right □ Head □ □ □ Neck □ □ □ Shoulder □ □	g this pa gs On A Q Q Q Q Q Q Q Q Q Q Q Q	in ggravates 0 0 0 0 0	Relieves
Headaches	L Front of Head Front of Head Back of Head L L L L L L L L	R R R R R R R R R R R R R R R R R R R	B C C C C C C C C C C C C C C C C C C C	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ In the A.M. □ In the A.M. □ 1/2 to 3/4 of awake time □ Most all the time □ In the P.M. □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending left 5. Does this pain radiate into other body parts? □ Bending right □ Head □ □ □ Neck □ □ □ Shoulder □ □ □ Arm □ □	g this pa gs On A Q Q Q Q Q Q Q Q Q	in ggravates C C C C C C C C C C C C C C C C C C C	Relieves
Headaches	L Front of Head Front of Head Back of Head L L L L L L L L	R R R R R R R R R R R R R R R R R R R	B C C C C C C C C C C C C C C C C C C C	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the A.M. 4. Pain Intensity (How it affects your daily activites) □ Doesn't affect □ Somewhat affects □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending tack □ Bending tack □ Doesn't affect □ Somewhat affects □ Bending tack □ Bending tack □ Doesn't affect □ Somewhat affects □ Bending tack □ Bending tack □ Doesn't affect □ Somewhat affects □ Bending tack □ Bending tack □ Bending right □ Twisting left □ Twisting left □ Twisting left □ Neck □ □ □ □ □ Standing □ Arm □ □ □ □ □ Standing □ Hand □ □ □ □ □ Standing	g this pa ps On A	in ggravates	Relieves
Headaches	L Front of Head Front of Head Back of Head L L L L L L L L	R R R R R R R R R R R R R R R R R R R	B B B B B B B B B B B B B B B B B B B	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the A.M. 4. Pain Intensity (How it affects your daily activites) □ Doesn't affect □ Somewhat affects □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending back □ Bending left □ Doesn't affect □ Somewhat affects □ Bending right □ Head □ □ □ Twisting left □ Neck □ □ □ Standing □ Arm □ □ □ Standing □ Hand □ □ □ Standing □ Hip □ □ □ Lifting	g this pa ps On A	in ggravates C C C C C C C C C C C C C C C C C C C	Relieves
Headaches	L Front of Head Front of Head Back of Head L L L L L L L L	R R R R R R R R R R R R R R R R R R R	B B B B B B B B B B B B B B B B B B B	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the P.M. 4. Pain Intensity (How it affects your daily activites) □ Doesn't affect □ Somewhat affects □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending toward □ Bending toward □ Doesn't affect □ Somewhat affects □ Bending toward □ Doesn't affect □ Somewhat affects □ Bending toward □ Bending toward □ Bending toward □ Bending toward □ Bending toward □ Coughing □ Sting tight □ Head □ □ □ Straining □ Arm □ □ □ Standing □ Hip □ □ □ Standing □ Lifting □ □ □ Uther Actions:	g this pa ps On A	in ggravates	Relieves
Headaches	L Front of Head Front of Head Back of Head L L L L L L L L	R R R R R R R R R R R R R R R R R R R	B B B B B B B B B B B B B B B B B B B	□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning □ Numbing □ Tingling □ Cramping □ Spasm □ Stinging □ Shooting □ Pounding □ Constrictin 3. Pain Frequency □ Up to 1/4 of awake time □ 1/4 to 1/2 of time □ Actions affecting □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the A.M. 4. Pain Intensity (How it affects your daily activites) □ Doesn't affect □ Somewhat affects □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending back □ Bending left □ Doesn't affect □ Somewhat affects □ Bending right □ Head □ □ □ Twisting left □ Neck □ □ □ Standing □ Arm □ □ □ Standing □ Hand □ □ □ Standing □ Hip □ □ □ Lifting	g this pa ps On A	in ggravates	

Patient Sign & Date:_____

____ Date:___

Description of Symptoms	(Describe your symptoms in the sections below, in the order of sev	verity, if possible.)
IV. Fourth Symptom: (Please check	off the boxes below to describe your 4th symptom. Describe only ONE	symptom per Section)
1. Check only one body location below	2. Types of pain	Other types of pain:
Headaches L R R B B Front of Head Top of Head	Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping Spasm Stinging Shooting Pounding Constriction	
Back of Head Jaw L R B Eye L R B Neck L R B Upper Back L R B Mid Back L R B Low Back L R B	3. Pain Frequency 6. Actions affecti	ng this pain ings On Aggravates Relieves
Chest L R B	Seriously affects Prevents activities Bending left 5. Does this pain radiate into other body parts? Bending right Left Right Both Head Image: Coupling Twisting right Neck Image: Coupling Sneezing Shoulder Image: Coupling Straining Hand Image: Coupling Straining Hip Image: Coupling Sitting Lifting Image: Coupling Straining	
Groot L R B B C	Other locations of radiation: Other Actions:	
V. Fifth Current Symptom:	(Please check off the boxes below to describe your 5th symptom).	
1. Check only one body location below Headaches L R B B Front of Head	2. Types of pain Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping	Other types of pain:
Top of Head	Spasm Stinging Shooting Pounding Constriction	
Back of Head Jaw L R B Eye L R B D	3. Pain Frequency 6. Actions affecti	
Neck L R B Upper Back L R B Mid Back L R B Low Back L R B Chest L R B	4. Pain Intensity (How it affects your daily activites) □ In the P.M. □ Doesn't affect □ Somewhat affects □ Seriously affects □ Prevents activities □ Bending left □ Bending left	
Abdomen L R B Ribs L R B Buttocks L R B Shoulder L R B Upper Arm L R B	5. Does this pain radiate into other body parts? Twisting left Left Right Both Head Image: Coupling Couphing Neck Image: Coupling Sneezing Shoulder Image: Coupling Image: Coupling	
□Forearm L R B □ □Hand L R B □ □Hip L R B □ □Leg L R B □	Hand	
General Foot Foot Foot Foot Foot Foot Foot Foo	Other locations of radiation:	
	Please check off the boxes below to describe your 6th symptom).	
1. Check only one body location below Headaches L R B B Front of Head	2. Types of pain Dull Dull	Other types of pain:
DTop of Head Back of Head	□Spasm □ Stinging □ Shooting □ Pounding □Constricti 3. Pain Frequency 6. Actions affecti	ng
Jaw L R B I Eye L R B I <td>□ Up to 1/4 of awake time □ 1/4 to 1/2 of time Bring □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M.</td> <td>gs On Aggravates Relieves</td>	□ Up to 1/4 of awake time □ 1/4 to 1/2 of time Bring □ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M.	gs On Aggravates Relieves
Upper Back L R B Image: Constraint of the state of the st	4. Pain Intensity (How it affects your daily activites) In the P.M. Doesn't affect Somewhat affects Seriously affects Prevents activities	
Abdomen L R B Ribs L R B Buttocks L R B Shoulder L R B	5. Does this pain radiate into other body parts? Left Right Both Head Neck Seck	
Upper Arm L R B Forearm L R B Hand L R B Hip L R B Leg L R B	Shoulder Image: Constraint of the straint of the s	
Geodesian Foot L C R C B C Other locations:	Foot Other Actions: Other locations of radiation: Other Actions:	

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Date:_

Descriptior				(Describe your symptoms in the sections below, in the order of severity			
VII. Seventh S				off the boxes below to describe your 7th symptom. Describe only ONE			
1. Check only o Headaches	ne body l	R 🛛	B	2. Types of pain	Other	types o	of pain:
DF DT DB	ront of Hea op of Head ack of Hea	ad J ad		Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping Spasm Stinging Shooting Pounding Constricting			
□Jaw □Eye □Neck □Upper Back		R 🔲 R 🔲 R 🔲 R 🔲	В 🔲 В 🔲 В 🔲	□ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the P.M.	js On Ag	igravates	Relieves
Mid Back Low Back Chest Abdomen	L 🔲 L 🔲 L 🔲	R 🗆 R 🗖 R 🗖	В 🔲 В 🔲 В 🔲	4. Pain Intensity (How it affects your daily activites) □ Bending forward □ Doesn't affect □ Somewhat affects □ Bending back □ Seriously affects □ Prevents activities □ Bending left 5. Does this pain radiate into other body parts? □ Twinting left			
Ribs Buttocks Shoulder Upper Arm		R 🛛 R 🗖 R 🗖	В 🔲 В 🔲 В 🔲	Left Right Both Twisting left Head Image: Comparison of the structure of the st			
□Forearm □Hand □Hip □Leg		R 🗆 R 🗖 R 🗖	B 🔾 B 💭 B 💭	Arm Image: Constraint of the standing Image: Constraint of the			
General Foot Other locations	L 🗖	R 🗖	в 🗖	Foot Image: Content of the content o			
VIII. Eighth Cu				(Please check off the boxes below to describe your 8th symptom).			
1. Check only of Headaches	ne body l	location b	B	2. Types of pain	Other	types o	of pain:
ТD	ront of Head	d		Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping Spasm Stinging Shooting Pounding Constricting	 		
⊔E ⊒Jaw	Back of Hea	ad R 🛛	в 🗖	3. Pain Frequency 6. Actions affectin	g this	-	
□Eye □Neck	L 🔲 L 🗖	R 🗖 R 🗖	в 🗖 в 🗖	\Box 1/2 to 3/4 of awake time \Box Most all the time \Box In the A.M.		ravates F	
Upper Back	L 🗖	R 🗖	в 🗖	4. Pain Intensity (How it affects your daily activites)			
Mid Back Low Back	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖	Doesn't affect Somewhat affects Bending back			
Chest	L 🗖	R 🗖	в 🗖	□ Seriously affects □ Prevents activities □ Bending left □ Bending right			
□Abdomen □Ribs	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖	5. Does this pain radiate into other body parts?			
Buttocks	L 🗖	R 🗖	в 🗖	Head U U I Wisting right			
Shoulder	L 🔲 L 🗖	R 🗖 R 🗖	в 🗖 в 🗖				
Forearm	L 🗖	R 🗖	в 🗖				
Hand	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖				
□Hip □Leg			вЦ				
Foot	L 🗖	R 🗖	в 🗖	Foot			
Other locations				Other locations of radiation:			
IX. Ninth Curre 1. Check only o				lease check off the boxes below to describe your 9th symptom). 2. Types of pain	Other	types o	of pain:
Headaches	L 🔲 ront of Head	R 🗖 ad	в 🗖	Dull Sharp Aching Cutting Throbbing Burning Numbing Tingling Cramping		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
□в	ack of Hea	ad		Spasm Stinging Shooting Pounding Constricting 3. Pain Frequency 6. Actions affecting		nain	
□Jaw □Eye	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖	Up to 1/4 of awake time 1/4 to 1/2 of time Brings		pam ravates R	Relieves
Neck	L 🗖	R 🗖	в 🗖	□ 1/2 to 3/4 of awake time □ Most all the time □ In the A.M. □ In the P.M.			
Upper Back	L 🔲 L 🛄	R 🗖 R 🗖	в 🗖 в 🗖	4. Pain Intensity (How it affects your daily activites)			
Low Back	L 🗖	R 🗖	в 🗖	Doesn't affect Somewhat affects Bending back			
Chest Abdomen	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖	❑ Seriously affects ❑ Prevents activities ❑ Bending left 5. Does this pain radiate into other body parts? ❑ Bending right			
	L 🗖		вО	Left Right Both Twisting left			
Buttocks	L 🗖	R 🗖	в 🗖	Head Image: Constraint of the sector of th			
Shoulder	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖	Shoulder			ŭ
Forearm	L 🗖	R 🗖	в 🗖	Arm D D Straining			
❑Hand ❑Hip	L 🔲 L 🔲	R 🗖 R 🗖	в 🗖 в 🗖	Hand Image: Constraint of the standing Hip Image: Constraint of the standing Standing Hip			
Leg	L 🗖	R 🗖	в 🗖		ū	ā	
General Foot	Г 🗖	R 🗖	в 🗖	Foot Image: Content of the content o			
Patient Sig	- 0 D-	-1		Date			

Patient Sign & Date:_____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty: $1 = $ "I can do it without any difficulty" $2 = $ "I can do it without much difficulty, despite some pain", $3 = $ "I manage to do it by myself, despite marked pain", $4 = $ "I manage to do it, despite the pain, but only if I have help", $5 = $ "I cannot do it at all, because of the pain". NOTE: Only fill in areas that are affected.
Difficulties with Self Care and Personal Hygiene Activities
Bathing Drying hair Brushing teeth Putting on shoes Preparing meals Taking out trash
Showering Combing hair Making bed Tying shoes Eating Doing laundry
Washing hair Washing face Putting on shirt Putting on pants Cleaning dishes Going to toilet
Difficulties with Physical Activities
Standing Walking Kneeling Bending back Twisting left Leaning back
Sitting Stooping Reaching
Reclining Squatting Bending forward Bending right Leaning forward Leaning right
Standing for long periods Kneeling for long periods Walking for long periods Kneeling for long periods
Difficulties with Functional Activities
Carrying small objects Lifting weights off floor Pushing things while seated Exercising upper body
Carrying large objects Lifting weights off table Pushing things while standing Exercising lower body
Carrying brief case
Carrying large purse Climbing inclines
Difficulties with Social and Recreational Activities
Bowling Jogging Swimming Ice Skating Competitive Sports Dating
Golfing Dancing Skiing Roller Skating Hobbies Dining out
Difficulties with Travelling
Driving a motor vehicle Riding as a passenger in a motor vehicle Riding as a passenger on a train
Driving for long periods of time Riding as a passenger on an airplane Riding as a passenger for long periods
Use the following 1 to 5 scale to describe the difficulties below:
1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability
in this area", 4 = " My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability"
Difficulties with Different Forms of Communication
Concentrating Hearing Listening Speaking Reading Writing Using a keyboard
Difficulties with the Senses
Seeing Hearing Sense of touch Sense of taste Sense of smell
Difficulties with Hand Functions
Grasping Holding Pinching Percussive movements Sensory discrimination
Difficulties with Sleep and Sexual Function
Being able to have normal, restful nights sleep Being able to participate in desired sexual activity
Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):
Defen Ormentene History
Prior Symptom History
Prior Similar Symptoms Has your History Contributed to your Current Symptoms?
L have NOT had prior symptoms similar to my current complaints.
A My current complaints DID exist before, but have not been bothering me. U My history HAS NOT contributed to my current symptoms.
U My current complaints ALREADY existed and were worsened.
My most recent prior similar symptoms (if applicable) occured 🔲 months ago / 🛛 years ago Or on Date:/
Write in below any other Prior Symptom History, not covered above: