

Patient name: _____

DATE: _____

1. Briefly describe your injury:

2. How did it occur:

3. Date of Injury:

4. Symptoms at onset:

5. Symptoms currently (past 3-5 days):

6. Pain level at worst : 0 1 2 3 4 5 6 7 8 9 10
(Zero being no pain, 10 being the worst pain you can imagine.)

7. Check any of the following that makes you feel WORSE:

- | | | | | | |
|------------------------------------|---------------------------------------|-------------------------------------|-----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> sitting | <input type="checkbox"/> working | <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> bending | <input type="checkbox"/> driving |
| <input type="checkbox"/> running | <input type="checkbox"/> sports | <input type="checkbox"/> housework | <input type="checkbox"/> lifting | <input type="checkbox"/> am | <input type="checkbox"/> pm/evening |
| <input type="checkbox"/> nighttime | <input type="checkbox"/> when still | <input type="checkbox"/> lying down | <input type="checkbox"/> reaching | <input type="checkbox"/> overhead activities | |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> other: _____ | | | | |

8. Check any of the following that makes you feel BETTER:

- | | | | | | |
|------------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> sitting | <input type="checkbox"/> working | <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> bending | <input type="checkbox"/> driving |
| <input type="checkbox"/> running | <input type="checkbox"/> sports | <input type="checkbox"/> housework | <input type="checkbox"/> lifting | <input type="checkbox"/> am | <input type="checkbox"/> pm/evening |
| <input type="checkbox"/> nighttime | <input type="checkbox"/> when still | <input type="checkbox"/> lying down | <input type="checkbox"/> reaching | <input type="checkbox"/> stretching | |
| <input type="checkbox"/> other: | _____ | | | | |

9. Generally, in what position do you spend most of your day (sitting at desk, standing, driving, up and down):

10. What activities can you no longer do or are difficult/painful because of this problem:

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