Name:	Patient Number:	Date:

SYMPTOM _____

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality:
- ❑Aching
- ❑Burning
- ❑Cramping
- ❑Deep
- ❑Diffuse
- ❑Dull
- ❑Numbness
- ❑Radiating
- ❑Sharp
- ❑Shooting
- ❑Stiffness
- ❑Tight
- ❑Tingling

Pain Frequency:
- ❑Constant
- ❑Frequent
- ❑Intermittent
- ❑Occasional

Pain radiates into:
- ❑Left Arm
- ❑Left Foot
- ❑Left Hand
- ❑Left Leg
- ❑Left Shoulder
- ❑Right Arm
- ❑Right Foot
- ❑Right Hand
- ❑Right Leg
- ❑Right Shoulder
- ❑Other: __________

Pain Cause:
- ❑A Fall
- ❑Work Injury
- ❑Auto Accident
- ❑Illness
- ❑Lifting Injury
- ❑Unknown
- ❑Gradual Onset

Pain Pattern:
- ❑Better in Morning
- ❑Better in Afternoon
- ❑Better in Evening
- ❑Worse in Morning
- ❑Worse in Afternoon
- ❑Worse in Evening
- ❑Consistent
- ❑Unchanged

What has been done before to treat this symptom?
- ❑Acupuncture
- ❑ Prescription medicine
- ❑Massage
- ❑ Surgery
- ❑OTC Medicines

Pain Duration:
- ❑_____Day(s)
- ❑_____Week(s)
- ❑_____Month(s)
- ❑_____Year(s)

Pain aggravated by:
- ❑Bending
- ❑Driving
- ❑Getting up/down
- ❑Increased Activity
- ❑Looking down
- ❑Overhead activities
- ❑Reaching
- ❑Sitting
- ❑Standing
- ❑Typing
- ❑Coughing
- ❑Exercising
- ❑House Work
- ❑Lifting
- ❑Lying down
- ❑Preparing food
- ❑Resting
- ❑Sneezing
- ❑Twisting
- ❑Walking

Pain relieved by:
- ❑Exercise
- ❑Ibuprofen
- ❑Knees Bent Up
- ❑Lying Down
- ❑No Movement
- ❑Resting
- ❑Standing
- ❑Support
- ❑Walking
- ❑Heat
- ❑Ice
- ❑Lifting
- ❑Medication
- ❑Reaching
- ❑Sitting
- ❑Stretching
- ❑Turning Head

For Doctor's Use Only:
What restrictions relate to the main impaired activity for this symptom?

Mode of onset and duration: