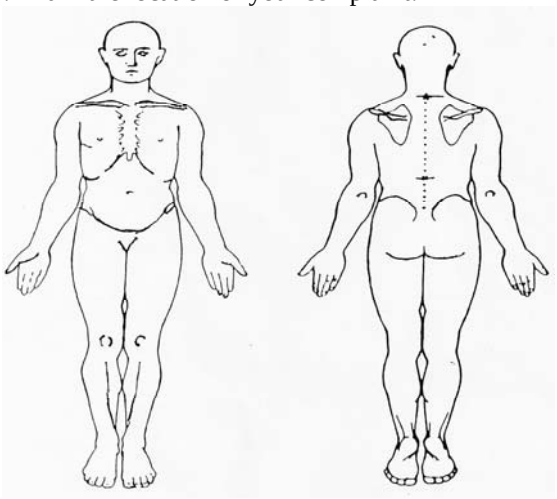
History of New or Current Episode

Name:_____ Today's Date:_____

1. Please circle the area or nature of your problem:
Headache Neck Pain **Upper Back Pain**
Low Back Pain Arm Pain Left/Right
Leg Pain Left/Right
Other:_____
_____

2. When did this **current episode** begin? Be specific—give a date and time—if possible:
_____
_____

3. Mark the location of your complaint:



4. Circle the cause of your symptoms:
Overexertion Strenuous Position
Auto Accident **Accident at Work**
Fall/Trip/Slip Woke up with pain
Other:_____
_____

5. Please circle the severity of your pain:
(A) I have no pain.
(B) I have pain, but it can be ignored.
(C) My pain requires me to change or modify how I do some things.
(D) My pain is bad enough that it prevents me from doing things I need/want to do
(E) My pain is so bad I have trouble with basic needs such as dressing myself.
(F) My pain is so bad I cannot get out of bed without assistance.

6. Mark your pain level on the scale below with an **X**:

No <- ->Worst
Pain Pain

7. Circle how often your pain occurs:
(A) Intermittent (25% of the time)
(B) Occasional (26-50% of the time)
(C) Frequent (51-75% of the time)
(D) Constant (76-100% of the time)
Other:_____
_____

8. Circle what your pain feels like:
Dull Sharp Stabbing Burning Throbbing
Other:_____
_____

9. Circle all below that relieve your pain:
Rest Walking Changing posture/position
Sitting **Standing** **Lying down** **Heating pad**
Wearing a brace Cold packs Pain creams
Nothing relieves my pain Other:_____
_____

10. Circle all below that aggravates your pain:
Cough **Sneeze** **Bowel Movement**
Lifting Bending Pushing Pulling
Driving **Riding in car** **Sitting**
Walking Running Standing
Changing body positions from: bed a chair the car
Other:_____

11. Circle any of the following unusual symptoms that you may have experienced since the onset of your problem:

Bowel/bladder changes **Numbness/tingling**
Talking difficulty Weakness
Falling **Unexplained weight loss**
Dizziness Swallowing difficulty
Upset stomache **Trouble seeing**
I do NOT have any of these symptoms

12. Circle the medications have you tried for your current problem:
Aspirin
Ibuprofen/Advil/Motrin
Acetaminophen/Tylenol
Naproxen Sodium/Aleve
Other:_____
_____

The information I have given above is true and correct:

_____
Signature Date