

For the following questions, answer the questions for your additional complaint.

(For example: neck pain or back pain). Area: \_\_\_\_\_

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Trip to ER)

- 0 None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9 Unbearable
- 10 Trip to ER

How did your symptoms begin? \_\_\_\_\_

When did your symptoms start? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Are your symptoms worse:  in the morning  by midday  at the end of the day  at night  throughout day

What describes the nature of your symptoms?

- dull
- sharp
- sharp with movement
- throbbing
- burning
- deep
- aching
- tingling
- stabbing
- cramping
- pinprick
- numbness
- radiating type of pain

Are your symptoms radiating?  Yes  No

Describe: \_\_\_\_\_

What activities aggravate your pain?

- sitting
- standing
- walking
- bending
- stooping
- lifting
- sleeping
- sneezing
- coughing
- straining
- twisting
- reaching
- looking up
- looking down
- movement
- rest
- laying on back
- driving
- typing
- scooping
- household chores
- exercise
- stair stepping
- Nothing aggravates it

Other: \_\_\_\_\_

What activities relieve your pain?

- sitting
- standing
- laying down
- knees are bent up
- rest occurs
- leaning against a support
- movement occurs
- no movement occurs
- analgesic topical pain relief gel is applied
- ice is applied
- heat is applied
- Nothing relieves it
- ibuprofen is taken
- medication is used
- stretching/exercise is used
- adjustments are provided

Other: \_\_\_\_\_

Have you seen anyone in the past for this complaint?  Yes  No

Who? \_\_\_\_\_

Have you had any tests (radiology) done for this complaint?  Yes  No

What? \_\_\_\_\_