

FULL NAME _____

DATE _____

AGE _____ OCCUPATION _____

RACE: Cauc. Black Hisp. Asian Am. Indian Other _____ Sex M F

PATIENT/INFORMANT STATES: _____

DETAILS OF CHIEF COMPLAINT:

DOCTOR'S NOTES:

1. **Location of Symptoms/Dysfunction:**

In order of onset: 1 _____ 2 _____ 3 _____ 4 _____

Intensity of pain: _____

(Patient's perception)

AMA Scale: Minimal 1-3, Slight 4-6, Moderate 7-9, Marked 10

Borg Scale: Normal 0, Low 1-3, Moderate 4-6, Intense 7-9, Emergency 10

1. Points To: _____

2. **Radiation/Spread/Referral of Pain:** Y N

2. _____

3. **Onset:**

When did it start? _____

Explanation: _____

How did it start?

WC PI MM MC C PA

Date of First Report: _____ Date of First Visit: _____

3. _____

4. **Type of Sensation:** _____

Quality of pain?/What does it feel like?

4. _____

5. **Frequency (Timing):**Intermit. 0-25 Occas. 26- 50 Frequent 51-75 Constant 76-100

5. _____

6. **Exacerbation/Aggravation/Increase:** Y N

Postures, activity, time of day, etc.

6. _____

7. **Symptoms/Dysfunction Since Onset Have:**Decreased Increased Remained About The Same Erratic

7. _____

8. **Change In Bodily Functions:**Y NBalance Bowel Habits Breathing CoordinationCoughing Gait Grip HearingMenstrual Sexual Sleep SneezingUrination Vision Weakness Weight

8. _____

9. **Handedness:** L R Am.

9. _____

FULL NAME _____

10. **Change In Activities of Daily Living:** Y N

What do you not do because of this problem?

Forgotten with activity Interferes with activity Activity continues

May prevent activity Prevents activity despite problem

10. _____

11. **Work Status: No. of Jobs 1 2 3**

Full-time Part-time Homemaker Student

Retired Disabled Unemployed Shift 1 2 3

11. _____

12. **Work/Home Disability:** Y N

Complete: _____ Days off work

_____ Days unable to perform household tasks

Partial: _____ Days of job modification

_____ Days of decreased household tasks

12. _____

13. **Store-bought or Home Remedies:** Y N

Care not recommended by a doctor.

Type/Effect: _____

13. _____

14. **Other Professional Care:** Y N

Type, Tests, Dx, Tx, Effect: _____

14. _____

15. **Remission/Relief/Decrease:** Y N

Postures, activities, time of day, etc.

15. _____

16. **Same or Similar Condition:** Y N

Explanation: _____

16. _____

17. **Concurrent Symptoms/Conditions:** Y N

Are you currently under a doctor's care for any other condition(s)?

17. _____

18. **Do You Have A Pacemaker or Any Other Surgically Implanted Device?** Y N

18. _____

19. **Are You Now or Could You Be Pregnant?** Y N

19. _____
