Work related? ❑ Yes ❑ No Motor vehicle related? ❑ Yes ❑ No

Describe Pain:

❑ Sharp ❑ Pins & Needles ❑ Stiff ❑ Ache

❑ Burning ❑ Throbbing ❑ Other _____

Does the pain radiate? If so, where? _____

Does it hurt more in ❑ Morning ❑ Afternoon ❑ Evening ❑ Constantly ❑ Disturbs Sleep

Does it hurt to cough or sneeze? ❑ Yes ❑ No

On a scale of 1-10 , place an X at your current pain level.

What is Your Pain Now

No Pain **Excruciating Pain**

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

At Best Past Week

No Pain **Excruciating Pain**

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

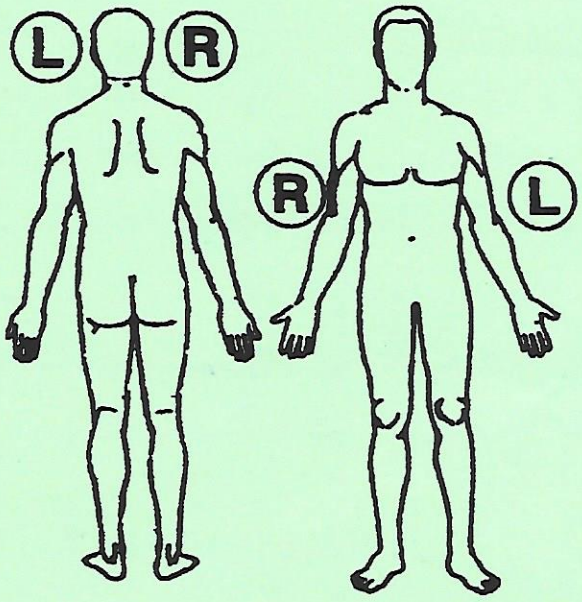
At Worst Past Week

No Pain **Excruciating Pain**

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Use Key Below Mark All Areas of Your Body Where You Feel Pain

Burning	x x x x x x x x
Stabbing	/ / / / / / / /
Ache	#### ####
Numbness	==== ====
Pins/ Needles	0000 0000
Other	**** ****



Have you missed time from work? ❑ Yes ❑ No If yes, last day worked _____

Are you working with any restrictions? ❑ Yes ❑ No If yes, what are they _____

What activities are you unable to do

At home _____

At work _____

Have you had for this condition (please check)

❑ X-Rays ❑ CT Scan ❑ MRI ❑ Bone Scan ❑ Electro Diag. Study ❑ Other

List medications _____

Date of last complete physical exam _____

Do you exercise regularly? ❑ Yes ❑ No If yes what do you normally do _____

_____

_____ How often _____

Which of the following aggravates your condition?

❑ Sitting down ❑ Sitting for long periods ❑ Standing ❑ Standing for long periods

❑ Walking ❑ Lying down ❑ Body movement ❑ Deep breathing ❑ Sleeping

❑ Specific Movements _____

❑ Other _____