

DIMOND CHIROPRACTIC & VAX-D CENTER

Date: _____

PT NUM # _____

Name: _____

First

MI

Last

Physical Address _____ City, State, Zip: _____

Mailing Address _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex M F Birth date: _____ Age Driver's License # & State: _____

SSN: _____ Check one: Married Single # of children: _____

Employer: _____ Occupation: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

Who can we thank for referring you to our office: _____

Reason for consulting this office: _____

Is this injury due to a work or auto accident? _____ Date of Injury: _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance Company: _____ Phone Number _____

Subscriber: _____ Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group# _____

Secondary Insurance Company: _____ Phone Number _____

Subscriber: _____ Date of Birth: _____ Relationship to Subscriber: _____

ID# _____ Group# _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents. I also authorize Dimond Chiropractic Center to release any information required to process my claims. I also hereby authorize Dr. Mark Barbee and whomever he may designate as assistants to administer care as deemed necessary.

Patient/Guardians Signature _____

<p>Privacy Practices Acknowledgement</p> <p>I have received the Notice of Privacy Practices and I have been provided an opportunity to review it</p> <p>Patient Name _____</p> <p>Signature _____</p> <p>Date of Birth _____</p> <p>Date _____</p>

Name: _____ Date: _____

Have you had previous chiropractic care? Y N

When, where, and for what condition?

People visit chiropractors for a variety of reasons and there are different levels of care. Please check the type of care you desire.

Stage 1 Pain Relief: Just get rid of the pain. Relief is short term

Stage 2 Rehabilitation: Get rid of the pain, but then fix this problem so that it doesn't come back!

Stage 3 Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic care so that I stay as healthy as possible.

Stage 4 Nutritional Health: I would be interested in spending money on an individualized nutritional program, tailored specifically to my needs.

What are your Major complaints?

When did this occur? _____

How long have you had this condition? _____

What do you feel caused this condition? _____

What activities aggravate your condition (s)? _____

Is this condition interfering with your: Work Sleep Daily routine Other _____

Is this condition progressively getting worse? Yes No Constant Comes and goes

Have you ever had a work or vehicular accident, or serious injury? Yes No

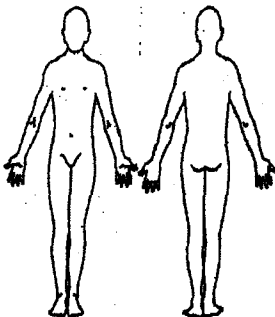
Please describe: _____

Have you ever broken any bones? YES NO

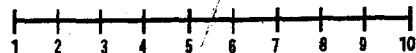
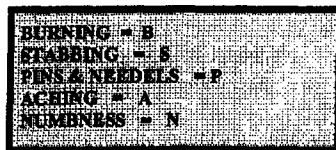
If yes please describe: _____

Has any other family member had the same or similar concerns? Yes No

If so please list whom and what condition:



If you have any of the symptoms shown in the diagram, indicate where they are by writing in the following letter in the affected area. Please mark the level of pain you experiencing on the 1 to 10 scale. Ten as being the worst and one being no pain



Patient History Form

Name: _____ Date: _____

Height: _____ Weight: _____

Please indicate if you have had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Soft Tissue |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Blood Clot / Phlebitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chronic Cough | |

If a blood relative has suffered from any of the following, Please place the proper initial in the space provided.

F= Father, M= Mother, G= Grandmother
S= Sibling, C=Child

- Arthritis
- Psoriasis
- Diabetes
- Gout
- Breast cancer
- Thyroid Disease
- High Blood Pressure
- Heart Disease
- Other cancer
- Tuberculosis

Please check conditions that have afflicted you in the past year:

- | | |
|---|--|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Weight gain / loss |
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Fever/ chills |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Chest Pain / Pressure | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Trouble Breathing | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Change in bowels habits |
| <input type="checkbox"/> Swelling of legs or feet | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Pain in legs | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Lymph gland swelling | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Seizures / convulsions | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Black out spells | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Fainting |

Please list any surgeries / Hospitalizations:

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____

List any drug allergies / intolerance:

List all medications currently being used:

Name:	Dose:
_____	_____
_____	_____

Please check if it applies to you:

Alcohol use: Never Rarely
 Moderately Heavy

Tobacco: Never Quit
Type Used: Cigarettes Chew
 Cigar Pipe

Packs / Amount used each day: _____
Number of years used: _____

Family Physician: _____

Personal Information:

Last Name:		First Name:		Mid. Init.:
Address:		City, State, Zip:		
Home Phone:	Work Phone:		Social Security No.:	
Date of Birth:		Date of Injury/Onset:		
Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both				
Insurance Information: Policy Holder (if different than patient):			Policy No.:	

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type <input type="checkbox"/> Car <input type="checkbox"/> Station Wagon <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Large Truck <input type="checkbox"/> Bus Other _____	2. Your position in vehicle <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger Other _____	3. What was your vehicle doing at the time of the accident? <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating Other _____
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4. Time/Speed/Damage Time of accident _____ Your vehicle's speed: _____ mph Their vehicle's speed: _____ mph Damage to your vehicle <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	5. Details of Accident Visibility at time of accident <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Who hit who/what? <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you You hit...(object) _____	6. Road conditions Road conditions at time of accident <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and dry Point of impact <input type="checkbox"/> Head-On <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Read-End <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear
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7. Body Position, etc.

Did you see the accident coming? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does your vehicle have headrests? Yes <input type="checkbox"/> No <input type="checkbox"/> What was the position of your headrest at the time of the impact? <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck What was the direction of your head at the time of the impact? <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left
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Did driver side air bags deploy? Yes No Did passenger side airbags deploy? Yes No Did side airbags deploy? Yes No

8. Additional accident information
 In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident: Did your body strike the inside of your vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe: _____ Did you lose consciousness during the injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for how long? _____ Your vehicle's estimated damage? _____ Damage to their vehicle: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled Did police show up at the scene? Yes <input type="checkbox"/> No <input type="checkbox"/> Was an accident report filled out? Yes <input type="checkbox"/> No <input type="checkbox"/>	10. After the accident: Check off your symptoms right after and a few days following: <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Mid back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Neck pain <input type="checkbox"/> Nausea <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold feet <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Confusion <input type="checkbox"/> Nervousness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of taste <input type="checkbox"/> Depression <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Tension <input type="checkbox"/> Toe numbness <input type="checkbox"/> Anxious <input type="checkbox"/> Loss of smell <input type="checkbox"/> Irritability <input type="checkbox"/> Constipation <input type="checkbox"/> Chest Pain <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping problems Others: _____
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11. Emergency Room? Where did you go after the accident? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Hospital ER <input type="checkbox"/> Private Doctor How did you get there? <input type="checkbox"/> Drove self <input type="checkbox"/> Somebody else <input type="checkbox"/> Ambulance <input type="checkbox"/> Police Were X-rays done? Yes <input type="checkbox"/> No <input type="checkbox"/> Was lab work done? Yes <input type="checkbox"/> No <input type="checkbox"/> Body parts X-rayed? _____ What lab work? _____ The X-rays revealed: _____ Treatments: <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Ice Other: _____ Medications: _____ Follow-up instructions: _____	12. Treatment History: Fill in any other doctor(s) seen prior to your first visit to this office 1. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done? Yes <input type="checkbox"/> No <input type="checkbox"/> Types of treatments received: _____ How many treatments received? ____ Currently treating? Yes <input type="checkbox"/> No <input type="checkbox"/> Did treatments benefit you? Yes <input type="checkbox"/> No <input type="checkbox"/> Last visit date: ____/____/____ 2. Dr. _____ First visit date: ____/____/____ Types of treatments received: _____ How many treatments received? ____ Currently treating: Yes <input type="checkbox"/> No <input type="checkbox"/> Did treatments benefit you? Yes <input type="checkbox"/> No <input type="checkbox"/> Last visit date: ____/____/____
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Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.)

1. Check only one body location below <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B Other locations: _____				2. Types of pain <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____																																																															
3. Pain Frequency <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		6. Actions affecting this pain <table border="1"> <thead> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending back</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coughing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sneezing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Straining</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Standing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sitting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lifting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other Actions:</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
4. Pain Intensity (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities																																																																			
5. Does this pain radiate into other body parts? <table border="1"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> Other locations of radiation: _____					Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom.)

1. Check only one body location below <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B Other locations: _____				2. Types of pain <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____																																																															
3. Pain Frequency <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time		6. Actions affecting this pain <table border="1"> <thead> <tr> <th></th> <th>Brings On</th> <th>Aggravates</th> <th>Relieves</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> In the A.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> In the P.M.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending forward</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending back</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Bending right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting left</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Twisting right</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coughing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sneezing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Straining</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Standing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Sitting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lifting</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other Actions:</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>			Brings On	Aggravates	Relieves	<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
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<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
4. Pain Intensity (How it affects your daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities																																																																			
5. Does this pain radiate into other body parts? <table border="1"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> <th>Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> Other locations of radiation: _____					Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
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III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom.)

1. Check only one body location below <input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B Other locations: _____				2. Types of pain <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting Other types of pain: _____																																																															
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<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																
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<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																																

IV. Fourth Symptom: (Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

Headaches L R B

Front of Head

Top of Head

Back of Head

Jaw L R B

Eye L R B

Neck L R B

Upper Back L R B

Mid Back L R B

Low Back L R B

Chest L R B

Abdomen L R B

Ribs L R B

Buttocks L R B

Shoulder L R B

Upper Arm L R B

Forearm L R B

Hand L R B

Hip L R B

Leg L R B

Foot L R B

Other locations: _____

2. Types of pain

Dull Sharp Aching Cutting

Throbbing Burning Numbing Tingling Cramping

Spasm Stinging Shooting Pounding Constricting

3. Pain Frequency

Up to 1/4 of awake time 1/4 to 1/2 of time

1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects your daily activities)

Doesn't affect Somewhat affects

Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. Fifth Current Symptom: (Please check off the boxes below to describe your 5th symptom.)

1. Check only one body location below

Headaches L R B

Front of Head

Top of Head

Back of Head

Jaw L R B

Eye L R B

Neck L R B

Upper Back L R B

Mid Back L R B

Low Back L R B

Chest L R B

Abdomen L R B

Ribs L R B

Buttocks L R B

Shoulder L R B

Upper Arm L R B

Forearm L R B

Hand L R B

Hip L R B

Leg L R B

Foot L R B

Other locations: _____

2. Types of pain

Dull Sharp Aching Cutting

Throbbing Burning Numbing Tingling Cramping

Spasm Stinging Shooting Pounding Constricting

3. Pain Frequency

Up to 1/4 of awake time 1/4 to 1/2 of time

1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects your daily activities)

Doesn't affect Somewhat affects

Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Sixth Current Symptom: (Please check off the boxes below to describe your 6th symptom.)

1. Check only one body location below

Headaches L R B

Front of Head

Top of Head

Back of Head

Jaw L R B

Eye L R B

Neck L R B

Upper Back L R B

Mid Back L R B

Low Back L R B

Chest L R B

Abdomen L R B

Ribs L R B

Buttocks L R B

Shoulder L R B

Upper Arm L R B

Forearm L R B

Hand L R B

Hip L R B

Leg L R B

Foot L R B

Other locations: _____

2. Types of pain

Dull Sharp Aching Cutting

Throbbing Burning Numbing Tingling Cramping

Spasm Stinging Shooting Pounding Constricting

3. Pain Frequency

Up to 1/4 of awake time 1/4 to 1/2 of time

1/2 to 3/4 of awake time Most all the time

4. Pain Intensity (How it affects your daily activities)

Doesn't affect Somewhat affects

Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___ Drying hair ___ Brushing teeth ___ Putting on shoes ___ Preparing meals ___ Taking out trash ___
 Showering ___ Combing hair ___ Making bed ___ Tying shoes ___ Eating ___ Doing laundry ___
 Washing hair .. ___ Washing face ___ Putting on shirt ___ Putting on pants ___ Cleaning dishes ___ Going to toilet ___

Difficulties with Physical Activities

Standing ___ Walking ___ Kneeling ___ Bending back ___ Twisting left ___ Leaning back ___
 Sitting ___ Stooping ___ Reaching ___ Bending left ___ Twisting right ___ Leaning left ___
 Reclining ___ Squatting ___ Bending forward .. ___ Bending right ___ Leaning forward ___ Leaning right ___
 Standing for long periods ___ Sitting for long periods ___ Walking for long periods ___ Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___ Lifting weights off floor ___ Pushing things while seated ___ Exercising upper body ___
 Carrying large objects ___ Lifting weights off table ___ Pushing things while standing .. ___ Exercising lower body ___
 Carrying brief case ___ Climbing stairs ___ Pulling things while seated ___ Exercising arms ___
 Carrying large purse ___ Climbing inclines ___ Pulling things while standing ___ Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___ Jogging ___ Swimming ___ Ice Skating ___ Competitive Sports ___ Dating ___
 Golfing ___ Dancing ___ Skiing ___ Roller Skating ___ Hobbies ___ Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___ Riding as a passenger in a motor vehicle ___ Riding as a passenger on a train ___
 Driving for long periods of time ___ Riding as a passenger on an airplane ___ Riding as a passenger for long periods ___

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating..... ___ Hearing..... ___ Listening..... ___ Speaking..... ___ Reading..... ___ Writing..... ___ Using a keyboard..... ___

Difficulties with the Senses

Seeing..... ___ Hearing..... ___ Sense of touch..... ___ Sense of taste..... ___ Sense of smell..... ___

Difficulties with Hand Functions

Grasping..... ___ Holding..... ___ Pinching..... ___ Percussive movements..... ___ Sensory discrimination..... ___

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep..... ___ Being able to participate in desired sexual activity..... ___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms <input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints. <input type="checkbox"/> My current complaints DID exist before, but have not been bothering me. <input type="checkbox"/> My current complaints ALREADY existed and were worsened.	Has your History Contributed to your Current Symptoms? <input type="checkbox"/> My history HAS contributed to my current symptoms. <input type="checkbox"/> My history HAS NOT contributed to my current symptoms. <input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms.
My most recent prior similar symptoms (if applicable) occurred..... ___ <input type="checkbox"/> months ago / <input type="checkbox"/> years ago Or on Date: ___/___/___	

Write in below any other Prior Symptom History, not covered above: