Patient History: New Episode

Name: _____ DOB:_____ Date: _____

What are your symptoms? Briefly list all that apply with the most severe listed first.

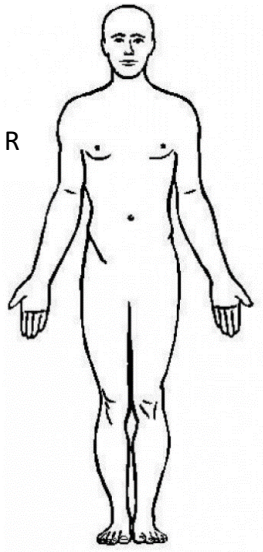
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

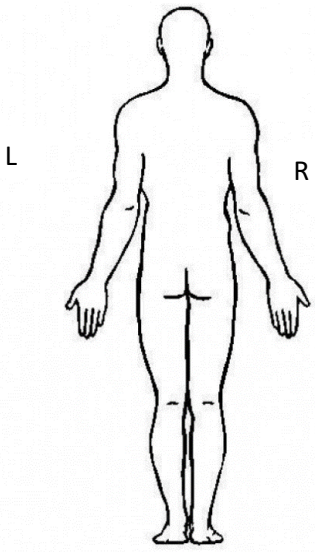
How did your symptoms occur? _____

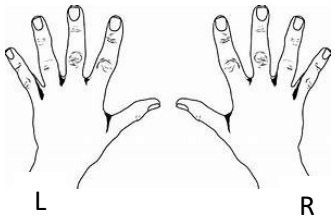
Date symptoms began (approximate): _____

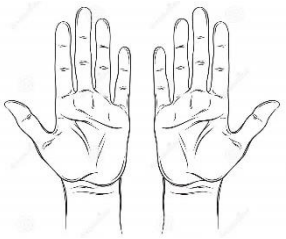
What is an activity that has gotten harder or more painful since this aggravation? _____

Using the provided pain key, mark the figure(s) below where you are experiencing pain.



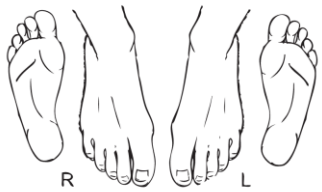






Pain Key

(((	Achy Pain
:::	Sharp Pain
XXX	Burning Pain
----	Numbness
000	Pins/Needles

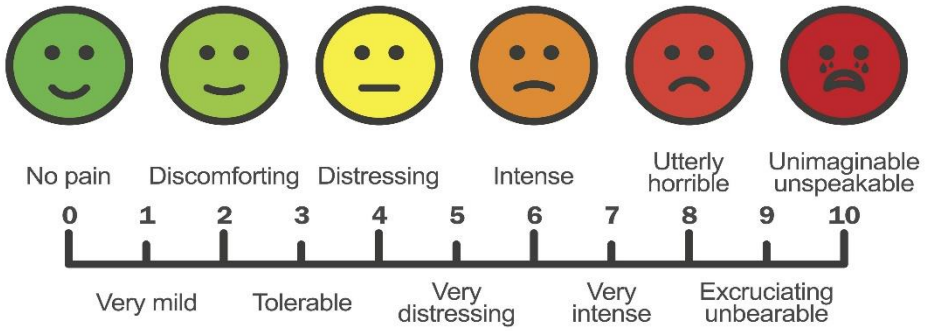


Try to rate **3 Activities of Daily Living** that apply to you. Firstly, mark whether the activity is *limited*, *painful* or *difficult* to do. Then, provide a number out of 10 for when the pain feels its *best*, its *worst*, on *average* this last week, and right *now*. **If an activity does not bother your symptoms, leave blank.** *L- Limited* *P- Painful* *D- Difficult*

Example: **L** Sitting to Standing: Best **1** /10 Worst **8** /10 On average **5** /10 Right now **3** /10

____**Sitting to Standing:**	Best _____/10	Worst____/10	On average_____/10	Right now____/10
____**Lifting:**	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Twist/turn:**	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Turning in bed:**	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Standing**:	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Walking:**	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Bending**:	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Sitting**:	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____**Using Computer:**	Best _____/10	Worst___/10	On average_____/10	Right now____/10
____ **Other**:	Best ___/10	Worst_____/10	On average_____/10	Right now____/10

For this section, according to the areas you marked that have pain, provide a number out of 10 for when the pain is at its *best*, its *worst*, on *average* this last week, and right *now*. **If you do not have pain in a specific area listed, leave it blank.**



Headaches:	Best:_____/10	Worst_____/10	On average_____/10	Right now_____/10
Neck:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Mid back:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Low back:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Hip:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Shoulder:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Arm:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Hand:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Leg:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Knee:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Foot:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10

If you have neck and/or back pain, circle your answers below when considering the last week:

1. **On average, how would you rate your pain?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
2. **How much has your pain interfered with your daily activities?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
3. **How much has your pain interfered with your recreational, social and family activities?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
4. **How much has your pain contributed to depressed feelings?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
5. **How much as your pain contributed to anxious feelings?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
6. **How have you felt your work has affected your pain?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
7. **How much have you been able to control your pain on your own? (10=no control)**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10

Clinic Use Only:

Height: _____

Weight: _____

Blood Pressure _____/_____