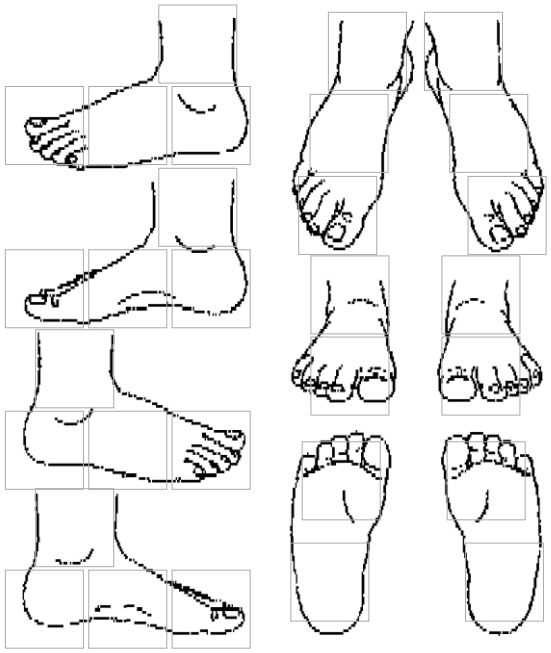
What is the main problem that brings you to our office today? _____

_____

Where is the problem located? Please mark on the diagram below.



How long ago did this problem start? _____

Did your pain or problem begin: ___ Suddenly ___ Gradually

Was this problem caused by an injury? ___ Yes ___ No

If yes, was It a work-related injury? ___ Yes ___ No

If yes, please describe: _____

How would you describe your pain? ___ sharp ___ dull ___ throbbing ___ aching ___ shooting ___ burning ___ numb ___ tingling ___ other

How would you rate your pain on a scale from 0 to 10?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible)

Since your pain or problem began, has it: ___ worsened ___ improved ___ remained unchanged

What makes your problem feel worse? ___ standing ___ walking ___ daily activities ___ running ___ dress shoes

___ other: _____

What makes your pain or problems feel better? ___ resting ___ ice ___ elevation ___ wrapping ___ massage

___ other: _____

What treatments have you had for this problem? _____

How has this problem affected your lifestyles or ability to work? _____

_____