Patient Basic Information

Personal Information: Last Name: First Name: Mid. Init.: Address: City, State, Zip: Work Phone: Home Phone: Social Security No.: Date of Birth: Date of Injury/Onset: Dominant Hand: □ Right □ Left ☐ 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	2. Your position in vehicle	3. What was your vehicle doing at the time of the accident?					
□ Car □ Station Wagon □ Van □ Pickup Truck □ Large Truck □ Bus Other	☐ Driver ☐ Front Passeng☐ Left Rear Passenger☐ Right Rear PassengerOther	r ☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light ☐ Making a right turn ☐ Making a left turn ☐ Parking ☐ Proceeding along ☐ Slowing down ☐ Accelerating Other ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐					
4. Time/Speed/Damage	5. Details of Accident	6. Road conditions					
Time of accident Your vehicle's speed:mph Their vehicle's speed:mph Damage to your vehicle Mild Moderate Totaled	Visibility at time of accident Poor Fair Good Who hit who/what? You hit other vehicle Other vehicle hit you You hit(object)	Road conditions at time of accident Icy Wet Sandy Dark Clean and dry Point of impact Head-On Left Front Right Front Read-End Left Rear Right Rear					
7. Body Position, etc.							
8. Additional accident information	t? Yes \(\text{No} \) No Yes \(\text{No} \) No Ss on? Yes \(\text{No} \) No Did passenger so tion	Does your vehicle have headrests? Yes □ No What was the position of your headrest at the time of the impact □ Even with top of head □ Even with bottom of head □ Middle of nec What was the direction of your head at the time of the impact? □ Facing straight forward □ Turned to the right □ Turned to the left de airbags deploy? Yes □ □ No Did side airbags deploy? Yes □ □ No stion here that is not covered by the above check offs.					
9. During the accident:		10. After the accident:					
Did your body strike the inside of If yes, describe: Did you lose consciousness during If yes, for how long? Your vehicle's estimated damage: Did police show up at the way of the police was an accident reported.	ng the injury? Yes \(\bar{\text{No}}\) No ? \(\bar{\text{Mild}}\) Moderate \(\bar{\text{Tota}}\) Tota the scene? Yes \(\bar{\text{Ves}}\) No	Check off your symptoms right after and a few days following: Headache Dizziness Mid back pain Cold hands Low back pain Cold feet Neck stiffnes Confusion Nervousness Diarrhea Fainting Fatigue Loss of taste Depression Ringing in ears Tension Constipation Chest Pain Pain behind eyes Shortness of breath Sleeping problems Others:					
11. Emergency Room?		12. Treatment History:					
Where did you go after the acc ☐ Home ☐ Work ☐ H How did you get there? ☐ Drove self ☐ Somebody else Were X-rays done? Yes ☐ N Body parts X-rayed?	ospital ER □ Private Doctor □ □Ambulance □ Police lo Was lab work done? Yes □□	Fill in any other doctor(s) seen prior to your first visit to this office 1. Dr First visit date:/ Specialty: X-raysdone? Yes □ No Types of treatments received: Currently treating? Yes □ No Did treatments benefit you? Yes □ No Last visit date:/ First visit date:/					
Medications:	lce Other:	Types of treatments received: How many treatments received? Currently treating: Yes \(\subseteq \text{No} \) Did treatments benefit you? Yes \(\subseteq \text{No} \) Last visit date://					

Description									rder of severity, if pos			
I. First Curren	t Sympt	om: (Ple	ase check			scribe you	r first symp	otom.	Describe only ONE			
1. Check only or Headaches	ne body i L 🔲	R 🔲	Delow B □	2. Types of pa		_	_	_		Othe	types	of pain:
□Fr	ont of He	ad		Dull	☐ Sharp☐ Burnir			Cuttin				
	op of Head			☐Throbbing ☐Spasm	☐ Stingir	ng 🖵 Nur ng 🖵 Sho		Tingl	ing ☐ Cramping iding ☐ Constricting	,		
I □Jaw	ack of Hea	ad R □	в□	3. Pain Freque		ig — One	oung =		6. Actions affecting		in	
□ Eye		R 🔲	В	☐ Up to 1/4 of		e □1/4 to	1/2 of time		_			Relieves
□Neck	L 🔲	R 🔲	в 🔲	□ 1/2 to 3/4 of	awake tim	e 🖵 Most	all the time		In the A.M.			
Upper Back	L	R 🔲	В 🔲	4. Pain Intens	ity (How it	offooto vou	r doily ootiv		☐ In the P.M.☐ Bending forward			
☐Mid Back ☐LowBack		R □ R □	В □ В □	Doesn't affe		anecis you Somewha			Bending back	ă		<u> </u>
□ Chest		R 🔲	В	☐ Seriously af		Prevents			☐ Bending left			
Abdomen	בֿ בֿ	R 🔲	в 🔲	5. Does this p	ain radiat	e into othe	r body pai	rts?	Bending right			
Ribs	L	R 🛄	В 🔲		Left	Right	Both	,	☐ Twisting left☐ Twisting right☐			
Buttocks	L	R □ R □	ВП	Head					Coughing	ā		_
☐ Shoulder ☐ Upper Arm		R 🔲	В П В П	☐ Neck☐ Shoulder					☐ Sneezing			
Forearm	<u></u>	R 🗖	в	☐ Shoulder ☐ Arm	ä				Straining			
□Hand	L 🔲	R 🛄	в 🛄	☐ Hand	ā		ā		☐ Standing☐ Sitting			
□Hip		R 🔲	В	☐ Hip					☐ Lifting		ă	
□ Leg □ Foot		R □ R □	В □ В □	Leg Foot					Other Actions:	_		_
Other locations		N U	D -	Other locatio			Ц	_				
II Second Cur	rront Cu	mntom					o doscribo	–	ext symptom).			
II. Second Cur 1. Check only or	ne body	location	below	2. Types of pa		ves pelow (o describe ;	your ne	ext symptom).	Othe	types	of pain:
☐Headaches_	L 🔲 İ	R 🗖	В 🗖	Dull Dull	☐ Sharp	☐ Ach	ina 🗆	Cuttin	na		٠.	•
	ront of He op of Hea			Throbbing	☐ Burnir	ng 🚨 Nur	mbing 🗆	1 Tingli	ing			
	ack of He			Spasm	Stingir	ng 🖵 Sho	ooting \Box	Poun				
□Jaw	L	R □	в 🗖	3. Pain Freque		□1/4 to	1/2 of time		6. Actions affecting			s Relieves
Eye	L 🔲	R 🔲	В	□ 1/2 to 3/4 of					☐ In the A.M.		- Ggravato	
□Neck □Upper Back	L 🔲	R □ R □	В □ В □						In the P.M.			
☐ Mid Back	בֿ בֿ	R 🗖	В	4. Pain Intens				rites)	Bending forward			
□LowBack	L 🛄	R 🛄	В 🛄	☐ Doesn't affe		Somewha Prevents a			☐ Bending back ☐ Bending left		ä	
Chest	L 📙	R 🔲	В					— г	Bending right			
☐ Abdomen ☐ Ribs	L 🔲	R □ R □	В □ В □	5. Does this p	aın radiat Left	e into otne Right	r body par Both		Twisting left			
Buttocks	ב ב	R 🗖	В	☐ Head					Twisting right			
Shoulder	L 🔲	R 🔲	в 🗖	☐ Neck					☐ Coughing☐ ☐ Sneezing			
☐ Upper Arm	L 🔲	R 🔲	В	Shoulder					Straining	ā		_
☐ Forearm ☐ Hand		R □ R □	В П В П	☐ Arm ☐ Hand					☐ Standing			
Hip		R 🗖	В	Hip	ă	ā	ă	[Sitting			
Leg	L	R 🗖	В□	Leg					Lifting Other Actions:	ш		ш
□Foot	L	R 🗖	В	Foot	<u> </u>	🗖			Julei Actions.			
Other locations				Other locatio				_				
III. Third Curre				Please check off		below to de	scribe your	r 3rd sy	/mptom).			
 Check only or ☐Headaches 		R 🔲	B 🔲	2. Types of pa	ain Sharp	ا ۸ مام	:	1 0.44		Otne	types	of pain:
	ont of He			☐ Dull ☐ Throbbing	☐ Snarp		nng □ mbina □	Cuttii Tingl				
	op of Head ack of Hea			Spasm	☐ Stingir			l Poun]		
□Jaw	L 🔲	R 🗖	в 🗖	3. Pain Freque			4/0 4 4	6	6. Actions affecting	this pa	in	
Eye	L 🔲	R 🔲	в 🗖	☐ Up to 1/4 of a ☐ 1/2 to 3/4 of							~	s Relieves
Neck		R 🔲	ВП	1/2 10 3/4 01	awake um	e 🗀 Most			☐ In the A.M. ☐ In the P.M.			
☐Upper Back ☐Mid Back	L 🔲 L 🔲	R □ R □	В П В П	4. Pain Intens					Bending forward	ā	ā	_
LowBack	בֿ בֿ	R	В	Doesn't affe		Somewha			☐ Bending back			
☐ Chest	L 🔲	R 🗖	в 🗖	Seriously af	fects $lacks$	Prevents a	activities	[Bending left			
Abdomen	<u> </u>	R 🔲	ВП	5. Does this p					☐ Bending right☐ Twisting left			
☐ Ribs ☐ Buttocks	L	R □ R □	В □ В □	☐ Head	Left	Right	Both		Twisting right	ā		
Shoulder		R 🔲	В	□ Neck	ă		ā		☐ Coughing			
□ Upper Arm	L	R 🔲	в 🔲	☐ Shoulder					Sneezing			
Forearm	L 📙	R 🔲	В□	□ Arm					☐ Straining☐ Standing			
☐Hand ☐Hip		R □ R □	В П В П	☐ Hand ☐ Hip					☐ Standing ☐ Sitting	ă	ă	
Leg		R 🔲	В	☐ Hip ☐ Leg	<u> </u>		ä		☐ Lifting			□
□Foot	L 🔲	R □	в	☐ Foot			□	C	Other Actions:			
Other locations:				Other locatio	ns of radia	tion:		1_				

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 2. Types of pain Other types of pain: □Headaches R □ ☐ Dull Aching Cutting ☐ Sharp ☐ Front of Head ☐ Numbina ☐ Throbbing ■ Burning ☐ Tingling Cramping ☐Top of Head □Spasm_ ☐ Stinging ☐ Shooting ☐ Pounding ☐ Constricting ☐ Back of Head 6. Actions affecting this pain 3. Pain Frequency □Jaw в 🗖 L \square R 🚨 ☐ Up to 1/4 of awake time \square 1/4 to 1/2 of time Brings On Aggravates L R 📮 В□ Relieves □ Eye □ 1/2 to 3/4 of awake time □ Most all the time ☐ In the A.M. L R □ в 🗖 □Neck ☐ In the P.M. R 🗖 в 📮 ☐ Upper Back L ■ Bending forward 4. Pain Intensity (How it affects your daily activites) R 🗖 В□ ☐ Mid Back L ☐ Bending back L в 🗖 Doesn't affect ☐ Somewhat affects R □ □Low Back ō ō ō ☐ Prevents activities ☐ Bending left ☐ Seriously affects ☐ Chest L R 🗖 в□ ■ Bending right $\bar{\Box}$ R □ в□ Abdomen 1 5. Does this pain radiate into other body parts? ■ Twisting left L 📮 в 📮 Ribs R □ Left Right Both ☐ Twisting right R 🗖 в 🗖 ■ Buttocks L ☐ Head Coughing в 🗖 ■ Shoulder R □ L ■ Neck ō ō ■ Sneezing R □ в□ ō ō ☐ Upper Arm L ☐ Shoulder □ Straining R □ в 🗖 Forearm L ☐ Arm ā ☐ Standing R □ в□ □ Hand L ā ā □ Hand ☐ Sitting ā ā ā R □ в□ □Hip L ō ō ☐ Hip ☐ Lifting L R 🗖 Leg в□ ☐ Lea Other Actions: L \square R 🔲 в 🗖 ☐ Foot ☐ Foot Other locations: Other locations of radiation: (Please check off the boxes below to describe your 5th symptom). V. Fifth Current Symptom: 1. Check only one body location below 2. Types of pain Other types of pain: L 🔲 □Headaches R 🗖 ☐ Dull □ Sharp Aching Cutting ☐ Front of Head ■ Burning ☐ Tingling ☐ Throbbing ■ Numbing ☐ Cramping ☐ Top of Head ☐ Pounding ☐ Constricting ☐ Stinging □ Spasm ■ Shooting ☐ Back of Head 6. Actions affecting this pain 3. Pain Frequency □Jaw R 📮 в□ ☐ Up to 1/4 of awake time \square 1/4 to 1/2 of time Brings On Aggravates Relieves R □ L в 🗖 □ Eye □ 1/2 to 3/4 of awake time □ Most all the time ☐ In the A.M. L 🗖 В **П** В **П** R 🗖 Neck ☐ In the P.M. R □ ☐ Upper Back L ā ☐ Bending forward 4. Pain Intensity (How it affects your daily activites L R □ в 🗖 ☐ Mid Back ☐ Bending back ☐ Somewhat affects □ Doesn't affect L R 🗖 в 📮 □I owBack ō ō Bending left Seriously affects Prevents activities ĪŌ R 🗖 в□ ☐ Chest ■ Bending right L 📮 в 📮 Abdomen R □ 5. Does this pain radiate into other body parts? ☐ Twisting left L R □ в 🗖 Ribs Left Right Both ☐ Twisting right ΙŌ в□ R □ ■ Buttocks □ Head ☐ Coughing в□ R 🗖 L Shoulder ■ Neck ō ō ō Sneezing ō ō L R □ в 🗖 ■UpperArm Shoulder Straining в 🗖 Forearm R □ **□** Arm L ā ā ☐ Standing ō R □ в 🗖 □Hand L □ Hand □ Sitting □Hip R □ в 🗖 L QiH 🔲 ☐ Lifting Leg L R □ в 🗖 □ Lea ō Other Actions: R 🗖 в 🗖 L 🚨 Foot ☐ Foot Other locations: Other locations of radiation: VI. Sixth Current Symptom: (Please check off the boxes below to describe your 6th symptom). 1. Check only one body location below 2. Types of pain Other types of pain: □Headaches R □ вП ☐ Dull □ Sharp Achina ☐ Cutting ☐ Front of Head ☐ Burning ■ Numbing ☐ Tingling ☐ Throbbing □ Cramping ☐ Top of Head ☐ Shooting ☐ Pounding □ Constricting □Spa<u>sm</u> ☐ Stinging ☐ Back of Head 3. Pain Frequency □Jaw 6. Actions affecting this pain R 📮 в 🔲 ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time □ Eye L R □ в□ Brings On Aggravates ☐ 1/2 to 3/4 of awake time ☐ Most all the time R 🗖 в 🗖 In the A.M. □Neck L ☐ In the P.M. В **П** В **П** ☐ Upper Back L R 📮 ō 4. Pain Intensity (How it affects your daily activites) ■ Bending forward L R 🔲 ☐ Mid Back ■ Somewhat affects □ Doesn't affect ☐ Bending back L R □ в 🗖 □Low Back ☐ Prevents activities Seriously affects LŌ R □ ☐ Bending left в ☐ Chest ō ĪŌ ☐ Bending right ■ Abdomen R 🗖 В□ 5. Does this pain radiate into other body parts? ☐ Twisting left L в Ribs R 🔲 Left Right Both ☐ Twisting right L R 🔲 в 🗖 ■ Buttocks ☐ Head Coughing Ĺ R 🗖 в 🗖 ■ Shoulder ■ Neck ☐ Sneezing L R 🗖 в ō **□**UpperArm ☐ Shoulder ō Straining ā L R 🗖 в 🗖 ☐ Forearm ☐ Arm Standing ō ā R 🗖 в□ ā ☐ Hand Hand L □ Sitting qiH 🗖 L R 🔲 в 🗖 QiH 🔲 R □ ā ō ☐ Lifting в□ Leg Lea L Other Actions: LŌ ☐ Foot R 🔲 в□ ☐ Foot Other locations: Other locations of radiation:

(Describe your symptoms in the sections below, in the order of severity, if possible.)

Description of Symptoms

I 1 Chack anter	Symptom			OII THE DOXES D		onbe your runs	ymptom	. Describe only ONE s	sympto	III pei i	occion ,
		ocation b	elow	2. Types of p				<u></u>			of pain:
☐ Headaches L ☐ R ☐ B ☐ ☐ Front of Head				☐ Dull	☐ Sharp	Aching	☐ Cu				
☐ Top of Head				☐ Throbbing	Burning		☐ Tir	ngling			
☐ Back of Head				Spasm	Stinging	g Shooting	☐ Po	unding Constricting			
□ Jaw L □ R □ B □			3. Pain Frequency 6. Actions a □ Up to 1/4 of awake time □ 1/4 to 1/2 of time								
□Eye	L 🛄	R 🛄	в 🛄					☐ In the A.M.	gs On A	ggravates	Relieves
Neck	L 🔲	R 🔲	ВП	1/2 to 3/4 or	awake time	☐ Most all the	time	In the A.M. In the P.M.	7		<u> </u>
Upper Back	L	R □	ВП	4 Pain Intens	ity (How it at	fects your daily a	activites)	Bending forward	ă	ā	
☐Mid Back ☐LowBack		R □ R □	В □ В □	Doesn't affe	ect \square	Somewhat affect	ts 1	☐ Bending back			ā
□ Chest		R 🔲	ВП	☐ Seriously af		Prevents activitie		Bending left			
Abdomen	L	R 🗖	в 🗖			ito other body pa		Bending right		00000000	00000000000
Ribs	L 🔲	R 🔲	в 🔲	3. D000 tille pt		Right Both		☐ Twisting left			H
Buttocks	L	R 🔲	В	☐ Head				☐ Twisting right☐ Coughing			
Shoulder	L 🔲	R 🔲	ВП	☐ Neck				☐ Sneezing		Ī	
□UpperArm □Forearm		R □ R □	В П В П	Shoulder			,	☐ Straining		ā	ā
☐ Hand		R □	В	☐ Arm ☐ Hand				☐ Standing			
Hip	בֿ 🗖	R 🗖	В	☐ Hand			,	Sitting			
Leg	L 🔲	R 🔲	в 🔲	Leg				Lifting			Ц
□Foot	L 🔲	R 🗖	в 🗖	Foot				Other Actions:	П		
Other locations	3:			Other locatio	ns of radiat	ion:					
VIII. Eighth C	urrent Sv	mptom:		(Please chec	k off the bo	xes below to de	escribe v	our 8th symptom).			
1. Check only			below	2. Types of p		X00 D0.01. 12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rour our cympicm,	Other	types	of pain:
□Headaches	L 🔲 Š	R 🔲	В 🗖	Dull	☐ Sharp	□ Aching	☐ Cu	ıttina			•
	Front of He		I	Throbbing	☐ Burning		☐ Tir				
	Top of Hea Back of He	d d	I	□ Spasm [™]	Stinging			unding Constricting			
□Jaw	L \square	ad R □	в□	3. Pain Frequ				6. Actions affecting			_
□Eye	L 🔲	R 🗖	В			□ 1/4 to 1/2 of		Brings	On Ago	gravates	Relieves
□Neck	L	R 🗖	в 🗖	■ 1/2 to 3/4 or	awake time	☐ Most all the	time	☐ In the A.M.☐ In the P.M.			
Upper Back		R 🔲	В	4 Pain Intens	itv (How it a	ffects your daily	activites)	Bending forward	ö		
☐Mid Back	Ŀ 📙	R 🔲	ВП	Doesn't affe		Somewhat affect		Bending back			ā
□LowBack □Chest	L 🔲 L 🔲	R □ R □	В П В П	☐ Seriously af		Prevents activitie		☐ Bending left			
☐ Chest☐ Abdomen		R □ R □	В П			to other body pa	orte?	Bending right			
Ribs	<u> </u>	R 🗖	В	3. Dues tins po		Right Both		Twisting left			<u> </u>
		. ` 🖵			Leit	Mulli Doll					
□ Buttocks	L 🔲	R 🔲	в 🗖	☐ Head				☐ Twisting right			
Shoulder	L 🔲	R □ R □	В П В П	□ Neck				☐ Coughing			
☐ Shoulder ☐ Upper Arm	L 🔲 L 🛄	R □ R □ R □	В П В П	☐ Neck☐ Shoulder				☐ Coughing☐ Sneezing			
□ Shoulder □ Upper Arm □ Forearm	L 🔲 L 🔲	R □ R □ R □ R □	В П В П В П	☐ Neck☐ Shoulder☐ Arm				☐ Coughing☐ Sneezing☐ Straining☐ Standing		0000000	
□ Shoulder □ Upper Arm □ Forearm □ Hand		R 🔲 R 🔲 R 🔲 R 🔲	В П П П П В В В В В	☐ Neck☐ Shoulder☐ Arm☐ Hand				☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting	00000		
□ Shoulder □ Upper Arm □ Forearm □ Hand □ Hip		R	B B B B B B	☐ Neck☐ Shoulder☐ Arm☐ Hand☐ Hip	00000			Coughing Sneezing Straining Standing Sitting Lifting			0000000000
□ Shoulder □ Upper Arm □ Forearm □ Hand		R 🔲 R 🔲 R 🔲 R 🔲	В П П П П В В В В В	☐ Neck☐ Shoulder☐ Arm☐ Hand				☐ Coughing ☐ Sneezing ☐ Straining ☐ Standing ☐ Sitting			
☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Hip ☐ Leg		R R R R R R R R	8888888 8888888888	□ Neck □ Shoulder □ Arm □ Hand □ Hip □ Lea	0000000			Coughing Sneezing Straining Standing Sitting Lifting	00000		
Shoulder Upper Arm Forearm Hand Hip Leg Foot Other location	L	R R R R R R R	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Neck Shoulder Arm Hand Hip Leg Foot Other location	□ □ □ □ □ ns of radiat	ion:		Coughing Sneezing Straining Standing Sitting Lifting Other Actions:			_ _
Shoulder Upper Arm Forearm Hand Hip Leg Foot	L	R	B B B B B B B B B B B B B B B B B B B	Neck Shoulder Arm Hand Hip Leg Foot Other location	ns of radiat	ion:		Coughing Sneezing Straining Standing Sitting Lifting			
□ Shoulder □ Upper Arm □ Forearm □ Hand □ Hip □ Leg □ Foot Other location: IX. Ninth Curr 1. Check only of □ Headaches	L	R	B B B B B B B B B B B B B B B B B B B	Neck Shoulder Arm Hand Hip Leg Foot Other locatio	ns of radiat	ion:	ibe your	Coughing Sneezing Straining Standing Sitting Lifting Other Actions:			
Shoulder Upper Arm Forearm Hand Hip Leg Foot Other location: IX. Ninth Curr 1. Check only of the content of th	L	R	B B B B B B B B B B B B B B B B B B B	Neck Shoulder Arm Hand Hip Leg Foot Other location	ns of radiat	ion:	ibe your	Coughing Sneezing Straining Standing Sitting Lifting Other Actions:	Other	types	of pain:
Shoulder Upper Arm Forearm Hand Hip Leg Foot Other location: IX. Ninth Curr 1. Check only of Headaches	L	R	B B B B B B B B B B B B B B B B B B B	Neck Shoulder Arm Hand Hip Leg Foot Other locatio	ns of radiat	ion:	ibe your	Coughing Sneezing Straining Standing Sitting Lifting Other Actions:	Other		of pain:
Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations IX. Ninth Curr 1. Check only of Headaches	L	R	B	Neck Shoulder Arm Hand Hip Leg Foot Other location Please check of Throbbing Spasm Read	ns of radiat ff the boxes pain Sharp Burning Stinging	ion:	ibe your	Coughing Sneezing Straining Standing Stiting Lifting Other Actions: 9th symptom).	Other	types	of pain:
Shoulder Upper Arm Forearm Hand Hip Leg Foot Other locations IX. Ninth Curr 1. Check only of Headaches Upper Arm Headaches	L	R	B B B B B B B B B B B B B B B B B B B	Neck Shoulder Arm Hand Hip Leg Foot Other locatio Please check of Dull Throbbing Spasm 3. Pain Frequ	ns of radiat ff the boxes ain Sharp Burning Stinging Jency awake time	ion:below to descr	ibe your Cu Tir	Coughing Sneezing Straining Straining Standing Stitting Lifting Other Actions: 9th symptom). cutting ngling Cramping unding Constricting Brings	Other	types of	of pain:
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(Describe your symptoms in the sections below, in the order of severity, if possible.)

Description of Symptoms

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 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 Kneeling 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 ___ Exercisingarms____ Carrying large purse Climbing inclines Pulling things while standing ... __ Exercisinglegs 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 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.... 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** Has your History Contributed to your Current Symptoms? ☐ I have NOT had prior symptoms similar to my current complaints. ☐ My history HAS contributed to my current symptoms. ☐ My current complaints DID exist before, but have not been bothering me. ☐ My history HAS NOT contributed to my current symptoms. ☐ My current complaints ALREADY existed and were worsened. ☐ I'm NOT SURE if my history has contributed to my current symptoms. _ ☐ months ago / ☐ years ago Or on Date: ____/_ My most recent prior similar symptoms (if applicable) occured...... Write in below any other Prior Symptom History, not covered above: