

Circle a number indicating your current pain level

0 1 2 3 4 5 6 7 8 9 10

Circle a number indicating your worst pain level in the last 2 days.

0 1 2 3 4 5 6 7 8 9 10

0=No Pain

10=Worse Possible

AIDS	Yes ___	No ___
Allergies	Yes ___	No ___
Breathing problems	Yes ___	No ___
Cancer	Yes ___	No ___
Dental problems	Yes ___	No ___
Diabetes	Yes ___	No ___
Dizziness	Yes ___	No ___
Fibromyalgia	Yes ___	No ___
Headaches	Yes ___	No ___
Heart/Circ disease	Yes ___	No ___
Pacemaker	Yes ___	No ___
Pregnant now	Yes ___	No ___
Recent weight loss	Yes ___	No ___
Rheumatoid arthritis (RA)	Yes ___	No ___
Osteoarthritis (OA)	Yes ___	No ___
Seizures	Yes ___	No ___
Steroid use	Yes ___	No ___
Stroke/CVA	Yes ___	No ___
Surgeries	Yes ___	No ___
Previous treatment for	Yes ___	No ___
Current condition		

Please circle the correct response:

Physical condition prior to current injury:

Excellent, Good, Fair, Poor

Are you currently working? Yes No

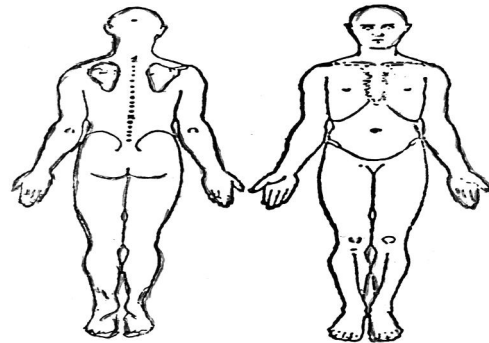
Occupation? _____

If yes, are you working full duty
light duty?

If no when was the last day you worked? _____

Please mark the location of your pain on the drawing and describe. Circle all that describe your pain.

Burning Shooting Achy Sharp
Stabbing Constant Intermittent



If you checked YES to any of the above please explain and give dates:

List current medications and state the condition that they are for:

Have you had a fall in the last year? If YES, How many and have you had an injury during the fall(s)?

Does your current injury limit the following activities?

	Not Limited	Difficult	Unable to perform		Not Limited	Difficult	Unable to perform
Sitting				Sleeping			
Standing				Flight of Stairs			
Standing up from sitting				Managing Children			
Walking				Preparing Food			
Rolling in bed				Squatting down			
Driving				Shopping			
Reaching				Lifting			
Stooping				Carrying			
Dressing				Walking Distances			