

**Current Health Status**

**Name:** \_\_\_\_\_

Describe Complaint: \_\_\_\_\_

Is it?  Increasing  Decreasing  Unchanged. Have you had this problem before?  Yes  No When? \_\_\_\_\_

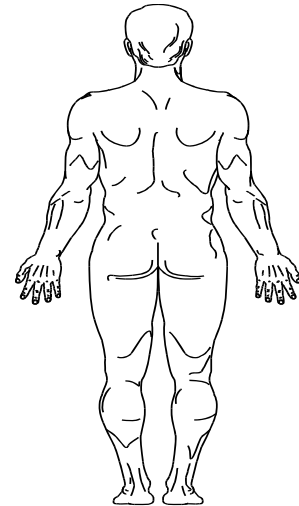
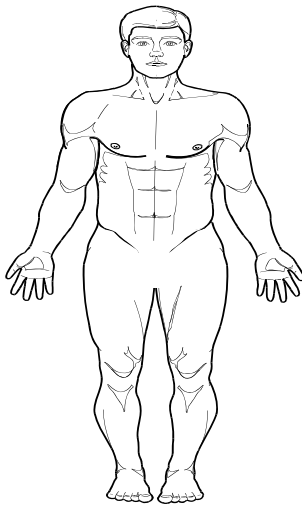
Does it interfere with any daily activities? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

What relieves it?  Pain relievers  Rest  Ice  Heat \_\_\_\_\_

Name of Doctor's treating this condition?  Current  Prior \_\_\_\_\_

**Shade in your area's of discomfort:**  
Pains, Aches, Tingling, Numbness, Spasm



**FREQUENCY** of your pain or complaint is? *(circle only one)*

**Constant** 100%   **Frequent** 75%   **Intermittent** 50%   **Occasional** 25%

**INTENSITY** of your pain or complaint is? *(circle only one)*

- Minimal:** Annoyance with no effect on activity
- Minor:** Tolerable with some impairment to activity
- Moderate:** Tolerable with marked impairment of activity
- Severe:** Intolerable and cannot perform any activity

**QUALITY** of your pain or complaint is?   **Dull**   **Achy**   **Sharp**   **Burning**   **Tingling**   **Numbness**   **Weak**

**PAIN SCALE:** On a scale of **1 - 10** what is your overall pain level?   1   2   3   4   5   6   7   8   9   10

**AWAKE TIME:** When you are awake (~16hrs) what percentage of time do you experience any pain? \_\_\_\_\_%

If this is not taken care of, how would it affect you? \_\_\_\_\_

Current Health Status?    Excellent    Good    Fair    Poor    Unhappy with health.    No progress elsewhere.

Any concerns? \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_