

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

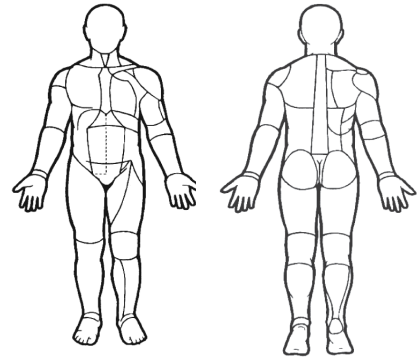
Is this condition getting progressively worse? YES NO UNKNOWN

Are you having trouble sleeping? YES NO

Normal hours of sleep: _____ hours Current hours of sleep: _____ hours

Have you had any prior treatment for your current condition? (check all that apply)

- Hospitalization Bracing/Taping/Casting Physical Therapy Surgery
 TENS/Stimulation Unit Injections Chiropractic Acupuncture
 Other _____



Mark an X on the picture where you continue to have pain, numbness or tingling.

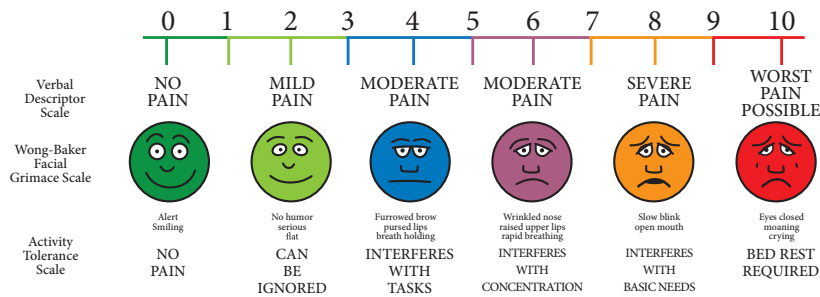
Before the onset of my current symptoms (or prior to injury), I was:

- Independent in all activities
 Independent with self-care only
 Needing assistance with some activities
 Needing assistance with most activities
 Dependent for all care

What is your level of pain at rest? _____

What is your pain with activity? _____

UNIVERSAL PAIN ASSESSMENT TOOL



- Medical conditions you currently have or have had in the past:
- | | |
|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> A wound that does not heal |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Unusual skin condition |
| <input type="checkbox"/> Calf pain with exercise | <input type="checkbox"/> Lung disease/problems |
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Recent accident | <input type="checkbox"/> Swollen and painful joints |
| <input type="checkbox"/> Head Trauma/concussion | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Muscular weakness | <input type="checkbox"/> Stomach pain or Ulcer |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Back or neck injuries |
| <input type="checkbox"/> Joint dislocation | <input type="checkbox"/> Pain with cough or sneeze |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Muscular pain with activity |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Frequent falls |
| <input type="checkbox"/> Epilepsy/Seizures/convulsions | <input type="checkbox"/> Chest pain or pressure at rest |
| <input type="checkbox"/> Constant pain unrelieved with rest | <input type="checkbox"/> Nervous or emotional problems |
| <input type="checkbox"/> Mouth numbness | <input type="checkbox"/> Pacemaker/implanted stimulator |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bowel/bladder problems |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes: type _____ |
| <input type="checkbox"/> Weakness or fatigue | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Swollen ankles or legs |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Night pain while sleeping |
| <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Any infectious disease (TB, Aids, Hepatitis) | <input type="checkbox"/> Pregnancy |

- HABITS**
- Smoking Packs/day _____
 Alcohol Drinks/week _____
 Coffee/Caffeine Drinks Cups/day _____
 High Stress Level Reason _____

- ALLERGIES**
- _____

- PRIOR SURGERIES**
- _____

- MEDICATIONS**
- _____

- EXERCISE**
- None Moderate Daily Heavy
- Type _____
- Times per week _____

- WORK ACTIVITY**
- Employed Employed with restrictions
 On medical leave Not employed Retired
- Type of Work _____
- Sitting Standing Light Labor Heavy Labor