

CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's date: ___/___/___						
PATIENT INFORMATION						
Patient's last name: _____		First: _____	Middle Initial: _____	Nickname: _____	Date of Birth: _____/_____/_____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address: _____			Work Phone: _____	Home Phone: _____	Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Address Line 2: _____			Cell Phone: _____	Cell Service Provider: _____		
City: _____	State: _____	Zip Code: _____	Email: _____			
Would you like to receive appointment reminders? Choose ONE: <input type="checkbox"/> Email <input type="checkbox"/> Text Message <input type="checkbox"/> Phone Call <input type="checkbox"/> None						
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Russian <input type="checkbox"/> Portuguese <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____						
Please check ALL races that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Decline to Answer						
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic nor Latino <input type="checkbox"/> Declined to Answer						
Preferred Communication: <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person						
Smoking Status: <input type="checkbox"/> Current everyday <input type="checkbox"/> Current some days <input type="checkbox"/> Former <input type="checkbox"/> Never Start Year _____ Quit Date _____						
Current Medications:						
1. Drug Name: _____		Strength (eg. 10MG) _____	Dose (e.g. 1 tab) _____		Frequency (e.g. once daily) _____	
2. Drug Name: _____		Strength (eg. 10MG) _____	Dose (e.g. 1 tab) _____		Frequency (e.g. once daily) _____	
3. Drug Name: _____		Strength (eg. 10MG) _____	Dose (e.g. 1 tab) _____		Frequency (e.g. once daily) _____	
4. Drug Name: _____		Strength (eg. 10MG) _____	Dose (e.g. 1 tab) _____		Frequency (e.g. once daily) _____	
5. Drug Name: _____		Strength (eg. 10MG) _____	Dose (e.g. 1 tab) _____		Frequency (e.g. once daily) _____	
Drug Allergies:						
1. Drug Name _____		Reaction (e.g. hives) _____	Date Started: _____			
2. Drug Name _____		Reaction (e.g. hives) _____	Date Started: _____			
3. Drug Name _____		Reaction (e.g. hives) _____	Date Started: _____			
Referred by: _____			Referring Physician?: _____			
Alcohol Use: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		Drug Use: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		Exercise: <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		
INSURANCE INFORMATION						
Primary Insurance: _____			Insured ID: _____			
Insured Name: _____			Group Number: _____			
Patient is the <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> _____ to the insured.				Ins. Date of Birth: _____		
Insured Address (if different from patient): _____						
Address 2: _____			City: _____	State: _____	Zip Code: _____	
Deductible? _____			Coinsurance/Copay? _____			
Secondary Insurance: _____			Insured ID: _____			

Chronic Lower Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Septicemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/Brain Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Infant Death Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT HISTORY

Please describe your past accidents:

1. Accident: _____ Job Auto Other Date: _____
 2. Accident: _____ Job Auto Other Date: _____
 3. Accident: _____ Job Auto Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
 2. Surgery: _____ Date: _____
 3. Surgery: _____ Date: _____

Do you have any implants? Yes No If yes, please describe _____

Are you currently pregnant? Yes No If yes, please list your due date: _____

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

AIDS	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Constipation	<input type="checkbox"/>

Convulsions	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Herniated Disk	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	Loss of Bowel Control	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	Reproductive disorder	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Serious Injury	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Tumors or Growths	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>		<input type="checkbox"/>

SYMPTOMS			
On the following pages you will be asked to choose your symptoms from this list.			
Neck Pain	Upper Back Pain	Mid Back Pain	Low Back Pain
Left Shoulder Pain	Right Shoulder Pain	Left Hip Pain	Right Hip Pain
Left Knee Pain	Right Knee Pain	Left Leg Pain	Right Leg Pain
Stiff Neck	Headache	Left Hand Pain	Right Hand Pain
IMPAIRED ACTIVITIES			
To go with each symptom you are reporting, you will be asked to select the MAIN activity that is made more difficult by each symptom. Choose the activity out of the options below.			
Computer Use (extended)	Computer Use (Short time)	Concentrating	Cycling
Desk Work	Drawing	Driving	Exercise
Lying Down	Piano	Reading	Running
Sitting	Standing	Staying Asleep	Using the Phone
Walking	Yard Work	Bathing	Bending

Caring for Infirm Person	Neck Range of Motion	Child Care	Climbing Stair
Falling Asleep	Dressing	Golf	Hair Care
Kneeling	Lifting	Lifting Children	Lifting/Carrying Groceries
Looking over Shoulder	Lying Down	Needlework	Pet Care
Sexual Activities	Shaving	Sitting	Swimming

SYMPTOMS			
Please fill out the form below to describe your current symptoms.			
SYMPTOM 1			
Symptom (choose ONE from list on previous page):			
Pain rating (1-10, with 10 being worst imaginable):			
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10			
Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):			
Pain Quality: <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness	Pain Frequency: <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	Pain radiates into: <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	Pain Cause: <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset

<input type="checkbox"/> Tight <input type="checkbox"/> Tingling	<p align="center">Pain Pattern:</p> <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	<p align="center">What has been done before to treat this symptom?</p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	<p align="center">Pain Duration:</p> <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
<p align="center">Pain aggravated by:</p> <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<p align="center">Pain relieved by:</p> <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	
<p>For Doctor's Use Only: What restrictions relate to the main impaired activity for this symptom?</p>			

SYMPTOM 2

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

- 1 2 3 4 5 6 7 8 9 10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

<p>Pain Quality:</p> <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	<p>Pain Frequency:</p> <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	<p>Pain radiates into:</p> <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	<p>Pain Cause:</p> <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
	<p>Pain Pattern:</p> <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	<p>What has been done before to treat this symptom?</p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	<p>Pain Duration:</p> <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
<p>Pain aggravated by:</p> <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<p>Pain relieved by:</p> <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	
<p>Pain aggravated by:</p> <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking			
<p>For Doctor's Use Only: What restrictions relate to the main impaired activity for this symptom?</p>			

SYMPTOM 3

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

- 1 2 3 4 5 6 7 8 9 10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

<p>Pain Quality:</p> <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	<p>Pain Frequency:</p> <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	<p>Pain radiates into:</p> <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	<p>Pain Cause:</p> <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
	<p>Pain Pattern:</p> <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	<p>What has been done before to treat this symptom?</p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	<p>Pain Duration:</p> <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
<p>Pain aggravated by:</p> <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<p>Pain relieved by:</p> <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	
<p>Pain aggravated by:</p> <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking			
<p>For Doctor's Use Only: What restrictions relate to the main impaired activity for this symptom?</p>			

SYMPTOM 4

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

- 1 2 3 4 5 6 7 8 9 10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

<p>Pain Quality:</p> <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	<p>Pain Frequency:</p> <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	<p>Pain radiates into:</p> <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	<p>Pain Cause:</p> <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
	<p>Pain Pattern:</p> <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	<p>What has been done before to treat this symptom?</p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	<p>Pain Duration:</p> <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
<p>Pain aggravated by:</p> <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<p>Pain relieved by:</p> <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	
<p>Pain aggravated by:</p> <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking			
<p>For Doctor's Use Only: What restrictions relate to the main impaired activity for this symptom?</p>			

SYMPTOM 5

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

- 1 2 3 4 5 6 7 8 9 10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

<p>Pain Quality:</p> <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	<p>Pain Frequency:</p> <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	<p>Pain radiates into:</p> <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	<p>Pain Cause:</p> <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
	<p>Pain Pattern:</p> <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	<p>What has been done before to treat this symptom?</p> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	<p>Pain Duration:</p> <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
<p>Pain aggravated by:</p> <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<p>Pain relieved by:</p> <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	

For Doctor's Use Only:

What restrictions relate to the main impaired activity for this symptom?

SYMPTOM 6

Symptom (choose ONE from list on previous page):

Pain rating (1-10, with 10 being worst imaginable):

1 2 3 4 5 6 7 8 9 10

Main impaired activity made more difficult by above symptom (choose ONE from list on previous page):

Pain Quality: <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling	Pain Frequency: <input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional	Pain radiates into: <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____	Pain Cause: <input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
	Pain Pattern: <input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged	What has been done before to treat this symptom? <input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> OTC Medicines	Pain Duration: <input type="checkbox"/> _____ Day(s) <input type="checkbox"/> _____ Week(s) <input type="checkbox"/> _____ Month(s) <input type="checkbox"/> _____ Year(s)
Pain aggravated by: <input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting up/down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking down <input type="checkbox"/> Overhead activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing		<input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking	
		Pain relieved by: <input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent Up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking	
For Doctor's Use Only: What restrictions relate to the main impaired activity for this symptom? 			