

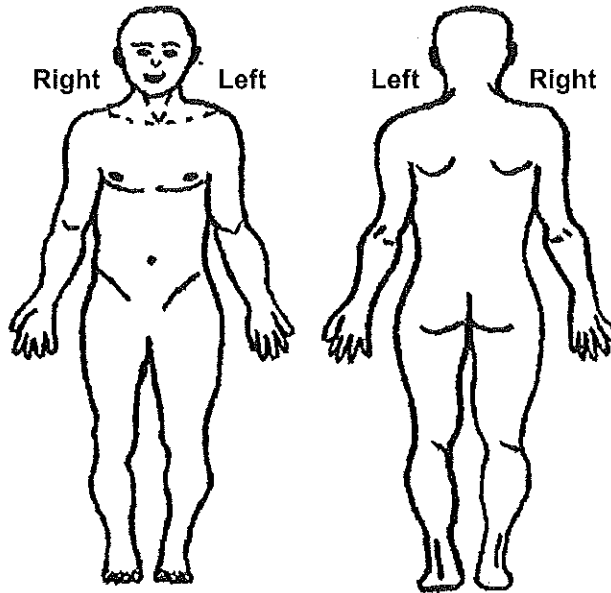
NEW PROBLEM
INFORMATION SHEET

NAME _____

DATE _____

Pain Diagram

Draw in the location of your symptoms in the diagram to the right using the symbols listed to indicate the type of pain you are experiencing.



- Numbness
|| || || ||
- Pins and Needles
0 0 0 0
- Burning
x x x x
- Stabbing
///
- Ache
^ ^ ^ ^

Pain Level if 0 represents no pain and 10 represents the worst pain imaginable circle the number that corresponds to your pain:

Today
0 1 2 3 4 5 6 7 8 9 10

Average pain this week
0 1 2 3 4 5 6 7 8 9 10

When did the symptoms start? _____

How did the pain begin?

- Spontaneously without a specific event causing the pain
- Due to a trauma or other event (explain below)

Since the pain began has it been?

- stable, about the same
- improving
- worsening

What makes the pain worse? (check all that apply)

- standing
- sitting
- lying on back
- lifting
- bending
- twisting
- coughing/sneezing
- reaching
- walking (how far can you walk before pain becomes intolerable? _____)
- other (explain) _____

What helps the symptoms?

- rest
- therapy
- medication (list _____)
- position _____
- activity _____
- other _____

Have you experienced any associated?

- numbness
- weakness
- loss of control of bladder/bowel

WHO ELSE HAVE YOU SEEN FOR THIS PROBLEM

NAME	SPECIALTY	ARE YOU STILL UNDER THEIR CARE

WHAT DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS CONDITION

TEST	DATE	WHERE WAS TEST DONE	RESULTS (IF KNOWN)
<input type="checkbox"/> X-RAYS			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT SCAN			
<input type="checkbox"/> BONE SCAN			
<input type="checkbox"/> EMG/NCS			

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION

TREATMENT	DID IT HELP	COMMENTS
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Occupation? _____

Does your work involve?

- Heavy lifting (>60lbs) Medium lifting (30-50lbs)
 Light lifting (10-20lbs) No/minimal lifting (<10lbs)

Have you missed work or not been able to perform your regular work due to the symptoms?

- No Yes (explain _____)

If you had any prior episodes of pain similar to this or prior injuries to this area answer below:

When did prior symptoms begin? _____

What if any diagnosis were you given in the past?

- disc herniation sprain arthritis spinal stenosis
 other _____

Treatment for prior symptoms?

- surgery physical therapy chiropractic injections
 other _____

Recovery from prior symptoms/injury? complete incomplete

(OVER)