NAME_____ DATE_____
DATE OF BIRTH_____ FILE#_____

SYMPTOM DESCRIPTION

_____
_____
_____

DATE FIRST NOTICED_____

ONSET SUDDEN RELATED TO ACCIDENT YES
GRADUAL NO

_____

FREQUENCY OF PAIN
1. ONLY A RARE OCCURRENCE
2. A FEW HOURS PER DAY
3. MOST OF THE TIME
4. CONSTANT, NO REMISSION

_____

QUALITY OF PAIN _____SHARP _____DULL _____BURNING
_____ITCHING _____DEEP _____SUPERFICIAL
_____NO PAIN INVOLVED

DOES THE PAIN RADIATE TO ANY WHERE ELSE? IF SO, TO WHERE?_____
_____
_____

IT IS BETTER WHEN I: SIT STAND LIE DOWN
REST EXERCISE
OTHER_____

_____

IT IS WORSE WHEN I: SIT STAND LIE DOWN
INACTIVE EXERCISE
OTHER_____

_____

HOW SEVERE IS THE SYMPTOM?
1. MILD ANNOYANCE
2. INTERFERES WITH SOME ACTIVITIES
3. INTERFERES WITH MOST ACTIVITIES
4. INTERFERES WITH ALL ACTIVITIES

_____

IS THERE A TIME OF THE DAY/MONTH/YEAR WHEN THE SYMPTOM IS WORSE? YES/NO
IF SO, WHEN?_____

PREVIOUS TREATMENT FOR THE ABOVE CONDITION_____
_____

STATEMENT OF FACTS ARE TRUE AND COMPLETE_____
(SIGNATURE OF PATIENT OR GUARDIAN)