Patient Name: _____ Date Of Injury/Onset: _____ Visit # _____ Today's Date _____

Describe your symptoms in the sections below, ***In The Order Of Severity***, if possible.
DESCRIBE ONLY ONE SYMPTOM PER SECTION

#1 CURRENT SYMPTOM

Please Circle Only ONE Body Location Below

1. LOCATION OF SYMPTOM

Headaches	Left	Right	Both
Front Of Head	L	R	B
Top Of Head	L	R	B
Back Of Head	L	R	B
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

2. TYPES OF PAIN

Dull	Sharp	Aching
Cutting	Throbbing	Burning
Numbing	Tingling	Cramping
Spasm	Stinging	Shooting
Pounding	Constricting	

Other Types Of Pain:

3. PAIN FREQUENCY

O Up To 1/4 Of Awake Time
O 1/4 To 1/2 Of Awake Time
O 1/2 To 3/4 Of Awake Time
O Prevents Activities

4. PAIN INTENSITY

(How It Affects Your Daily Activities)

O Doesn't Affect O Somewhat Affects
O Seriously Affects O Prevents Activities

5. DOES THE PAIN RADIATE INTO OTHER BODY PARTS?

Head	L	R	B
Neck	L	R	B
Shoulder	L	R	B
Arm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

6. ACTIONS AFFECTING THIS PAIN

	Brings On	Aggravates	Relieves
In The A.M.	O	O	O
In The P.M.	O	O	O
Bend Forward	O	O	O
Bend Back	O	O	O
Bend Left	O	O	O
Bend Right	O	O	O
Twist Left	O	O	O
Twist Right	O	O	O
Coughing	O	O	O
Sneezing	O	O	O
Straining	O	O	O
Standing	O	O	O
Sitting	O	O	O
Lifting	O	O	O

Other Activities:

#2 CURRENT SYMPTOM

Please Circle Only ONE Body Location Below

1. LOCATION OF SYMPTOM

Headaches	Left	Right	Both
Front Of Head	L	R	B
Top Of Head	L	R	B
Back Of Head	L	R	B
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

2. TYPES OF PAIN

Dull	Sharp	Aching
Cutting	Throbbing	Burning
Numbing	Tingling	Cramping
Spasm	Stinging	Shooting
Pounding	Constricting	

Other Types Of Pain:

3. PAIN FREQUENCY

O Up To 1/4 Of Awake Time
O 1/4 To 1/2 Of Awake Time
O 1/2 To 3/4 Of Awake Time
O Prevents Activities

4. PAIN INTENSITY

(How It Affects Your Daily Activities)

O Doesn't Affect O Somewhat Affects
O Seriously Affects O Prevents Activities

5. DOES THE PAIN RADIATE INTO OTHER BODY PARTS?

Head	L	R	B
Neck	L	R	B
Shoulder	L	R	B
Arm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

6. ACTIONS AFFECTING THIS PAIN

	Brings On	Aggravates	Relieves
In The A.M.	O	O	O
In The P.M.	O	O	O
Bend Forward	O	O	O
Bend Back	O	O	O
Bend Left	O	O	O
Bend Right	O	O	O
Twist Left	O	O	O
Twist Right	O	O	O
Coughing	O	O	O
Sneezing	O	O	O
Straining	O	O	O
Standing	O	O	O
Sitting	O	O	O
Lifting	O	O	O

Other Activities:

#3 CURRENT SYMPTOM

Please Circle Only ONE Body Location Below

1. LOCATION OF SYMPTOM

Headaches	Left	Right	Both
Front Of Head	L	R	B
Top Of Head	L	R	B
Back Of Head	L	R	B
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

2. TYPES OF PAIN

Dull	Sharp	Aching
Cutting	Throbbing	Burning
Numbing	Tingling	Cramping
Spasm	Stinging	Shooting
Pounding	Constricting	

Other Types Of Pain:

3. PAIN FREQUENCY

O Up To 1/4 Of Awake Time
O 1/4 To 1/2 Of Awake Time
O 1/2 To 3/4 Of Awake Time
O Prevents Activities

4. PAIN INTENSITY

(How It Affects Your Daily Activities)

O Doesn't Affect O Somewhat Affects
O Seriously Affects O Prevents Activities

5. DOES THE PAIN RADIATE INTO OTHER BODY PARTS?

Head	L	R	B
Neck	L	R	B
Shoulder	L	R	B
Arm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

6. ACTIONS AFFECTING THIS PAIN

	Brings On	Aggravates	Relieves
In The A.M.	O	O	O
In The P.M.	O	O	O
Bend Forward	O	O	O
Bend Back	O	O	O
Bend Left	O	O	O
Bend Right	O	O	O
Twist Left	O	O	O
Twist Right	O	O	O
Coughing	O	O	O
Sneezing	O	O	O
Straining	O	O	O
Standing	O	O	O
Sitting	O	O	O
Lifting	O	O	O

Other Activities:

Patient Name: _____ Date Of Injury/Onset: _____ Visit # _____ Today's Date _____

Describe your symptoms in the sections below, ***In The Order Of Severity,*** if possible.
DESCRIBE ONLY ONE SYMPTOM PER SECTION

#4 CURRENT SYMPTOM

Please Circle Only ONE Body Location Below

1. LOCATION OF SYMPTOM

Headaches	Left	Right	Both
Front Of Head	L	R	B
Top Of Head	L	R	B
Back Of Head	L	R	B
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

2. TYPES OF PAIN

Dull	Sharp	Aching
Cutting	Throbbing	Burning
Numbing	Tingling	Cramping
Spasm	Stinging	Shooting
Pounding	Constricting	

Other Types Of Pain:

3. PAIN FREQUENCY

O Up To 1/4 Of Awake Time
O 1/4 To 1/2 Of Awake Time
O 1/2 To 3/4 Of Awake Time
O Prevents Activities

4. PAIN INTENSITY

(How It Affects Your Daily Activities)

O Doesn't Affect O Somewhat Affects
O Seriously Affects O Prevents Activities

5. DOES THE PAIN RADIATE INTO OTHER BODY PARTS?

Head	L	R	B
Neck	L	R	B
Shoulder	L	R	B
Arm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

6. ACTIONS AFFECTING THIS PAIN

	Brings On	Aggravates	Relieves
In The A.M.	O	O	O
In The P.M.	O	O	O
Bend Forward	O	O	O
Bend Back	O	O	O
Bend Left	O	O	O
Bend Right	O	O	O
Twist Left	O	O	O
Twist Right	O	O	O
Coughing	O	O	O
Sneezing	O	O	O
Straining	O	O	O
Standing	O	O	O
Sitting	O	O	O
Lifting	O	O	O

Other Activities:

#5 CURRENT SYMPTOM

Please Circle Only ONE Body Location Below

1. LOCATION OF SYMPTOM

Headaches	Left	Right	Both
Front Of Head	L	R	B
Top Of Head	L	R	B
Back Of Head	L	R	B
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

2. TYPES OF PAIN

Dull	Sharp	Aching
Cutting	Throbbing	Burning
Numbing	Tingling	Cramping
Spasm	Stinging	Shooting
Pounding	Constricting	

Other Types Of Pain:

3. PAIN FREQUENCY

O Up To 1/4 Of Awake Time
O 1/4 To 1/2 Of Awake Time
O 1/2 To 3/4 Of Awake Time
O Prevents Activities

4. PAIN INTENSITY

(How It Affects Your Daily Activities)

O Doesn't Affect O Somewhat Affects
O Seriously Affects O Prevents Activities

5. DOES THE PAIN RADIATE INTO OTHER BODY PARTS?

Head	L	R	B
Neck	L	R	B
Shoulder	L	R	B
Arm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

6. ACTIONS AFFECTING THIS PAIN

	Brings On	Aggravates	Relieves
In The A.M.	O	O	O
In The P.M.	O	O	O
Bend Forward	O	O	O
Bend Back	O	O	O
Bend Left	O	O	O
Bend Right	O	O	O
Twist Left	O	O	O
Twist Right	O	O	O
Coughing	O	O	O
Sneezing	O	O	O
Straining	O	O	O
Standing	O	O	O
Sitting	O	O	O
Lifting	O	O	O

Other Activities:

#6 CURRENT SYMPTOM

Please Circle Only ONE Body Location Below

1. LOCATION OF SYMPTOM

Headaches	Left	Right	Both
Front Of Head	L	R	B
Top Of Head	L	R	B
Back Of Head	L	R	B
Jaw	L	R	B
Eye	L	R	B
Neck	L	R	B
Upper Back	L	R	B
Mid Back	L	R	B
Low Back	L	R	B
Chest	L	R	B
Abdomen	L	R	B
Ribs	L	R	B
Buttocks	L	R	B
Shoulder	L	R	B
Upper Arm	L	R	B
Forearm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

2. TYPES OF PAIN

Dull	Sharp	Aching
Cutting	Throbbing	Burning
Numbing	Tingling	Cramping
Spasm	Stinging	Shooting
Pounding	Constricting	

Other Types Of Pain:

3. PAIN FREQUENCY

O Up To 1/4 Of Awake Time
O 1/4 To 1/2 Of Awake Time
O 1/2 To 3/4 Of Awake Time
O Prevents Activities

4. PAIN INTENSITY

(How It Affects Your Daily Activities)

O Doesn't Affect O Somewhat Affects
O Seriously Affects O Prevents Activities

5. DOES THE PAIN RADIATE INTO OTHER BODY PARTS?

Head	L	R	B
Neck	L	R	B
Shoulder	L	R	B
Arm	L	R	B
Hand	L	R	B
Hip	L	R	B
Leg	L	R	B
Foot	L	R	B

Other Locations:

6. ACTIONS AFFECTING THIS PAIN

	Brings On	Aggravates	Relieves
In The A.M.	O	O	O
In The P.M.	O	O	O
Bend Forward	O	O	O
Bend Back	O	O	O
Bend Left	O	O	O
Bend Right	O	O	O
Twist Left	O	O	O
Twist Right	O	O	O
Coughing	O	O	O
Sneezing	O	O	O
Straining	O	O	O
Standing	O	O	O
Sitting	O	O	O
Lifting	O	O	O

Other Activities:

Patient Name: _____ Date of Injury/Pain Began: _____ Today's Date: _____

Activities of Daily Living Assessment

Please fill in the blanks below using the 1 to 5 scale as indicated. Example: Sitting: 3

Keep in mind the pain that is causing you the most discomfort. If there is an activity listed that you do not participate in, please leave the blank empty. If you are uncertain about anything, please ask.

1 = "I can do this myself without ANY difficulty"
2 = "I can do this without much difficulty, in spite of SOME pain"
3 = "I manage to do this myself, in spite of MARKED pain"
4 = "I manage to do this, in spite of pain, BUT I need help"
5 = "I CANNOT do this at all because of the pain"

Difficulties with Self Care and Personal Hygiene Activities

Bathing:	Drying Hair:	Brushing Teeth:	Put on Shoes:	Prepare Meals:	Take out Trash:
Showering:	Combing Hair:	Making Bed:	Tying Shoes:	Eating:	Doing Laundry:
Washing Hair:	Washing Face:	Put on Shirt:	Put on Pants:	Clean Dishes:	Using Toilet:

Difficulties with Physical Activities

Standing:	Walking:	Kneeling:	Bend Back:	Twist Left:	Lean Back:
Sitting:	Stooping:	Reaching:	Bend Left:	Twist Right:	Lean Left:
Reclining:	Squatting:	Bend Forward:	Bend Right:	Lean Forward:	Lean Right:
Standing for long periods:	Sitting for long periods:	Walking for long periods:	Kneeling for long periods:		

Difficulties with Functional Activities

Carry small objects:	Lift weights off floor:	Push items while seated:	Exercise upper body:
Carry large objects:	Lift weights off table:	Push items while standing:	Exercise lower body:
Carry briefcase:	Climb stairs:	Pull items while seated:	Exercise arms:
Carry large purse:	Climb incline:	Pull items while standing:	Exercise legs:

Difficulties with Social/Recreational Activities

Bowling:	Jogging:	Swimming:	Ice Skating:	Comp. Sports:	Dating:
Golfing:	Dancing:	Skiing:	Roller Skating:	Hobbies:	Dining:

Difficulties with Travels

Driving:	Driving for long periods:	Riding in a vehicle:	Riding in a plane:	Riding in a train:	Riding for long periods:

Difficulties with Communication, Senses, and Hand Functions

Concentrating:	Hearing:	Listening:	Speaking:	Reading:	Writing:
Using Keyboard:		Seeing:	Touch:	Taste:	Smell:
Grasping:	Holding:	Pinching:			

Difficulties with Sleep: Able to have a restful night sleep: ___ Able to participate in desired sexual activity: ___

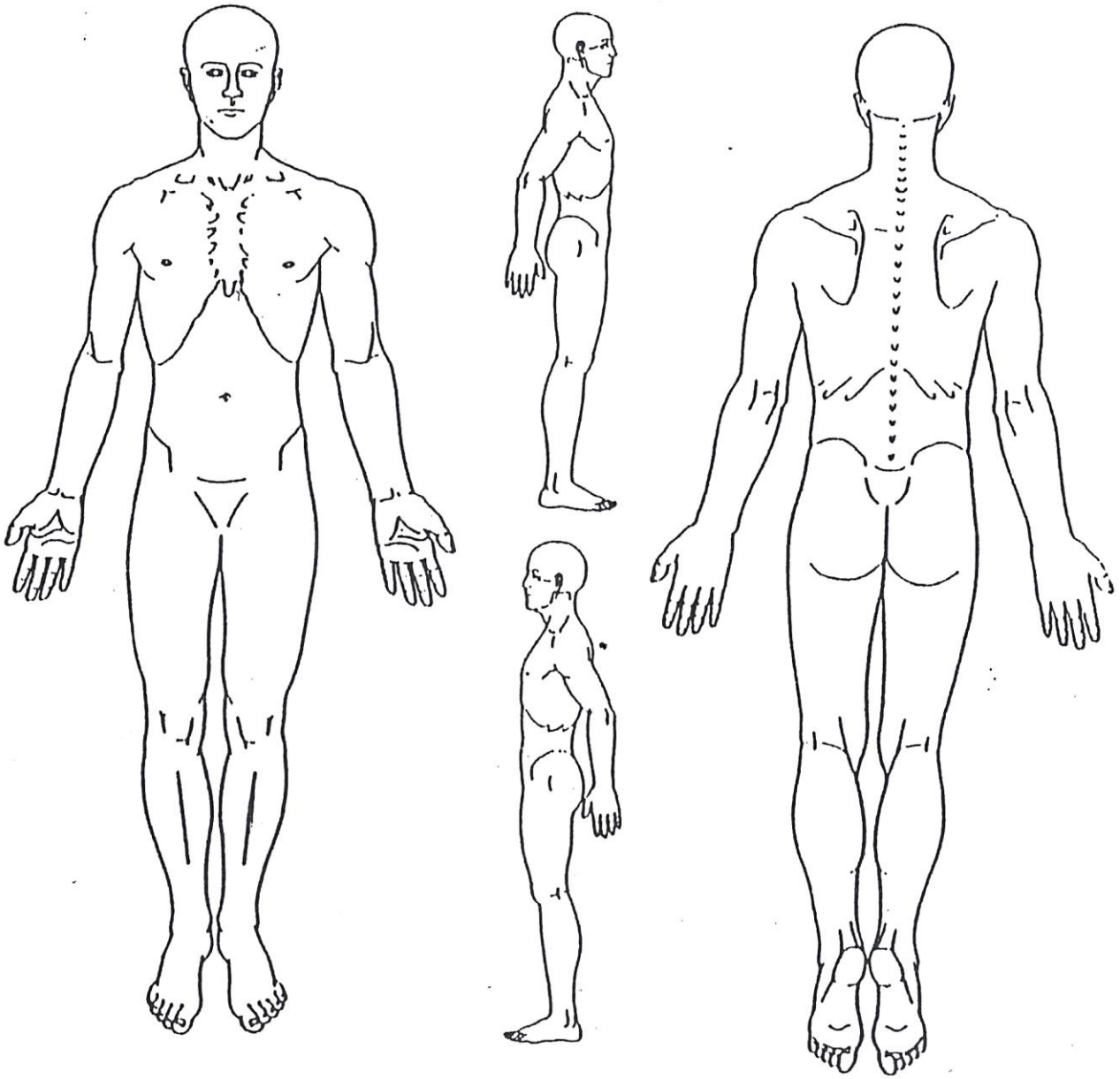
Please check one:

_____ I have NOT had prior symptoms similar to this complaint
_____ My complaint DID exist before, but has not bothered me
_____ My condition DID exist before and has worsened
My most recent PRIOR symptoms occurred ____ months/_____ years ago

OWESTRY PAIN DISABILITY QUESTIONNAIRE

Use the letters below to indicate the type and location of your sensations right now

A = Ache	**B** = Burning	**N** = Numbness
P = Pins and Needles	**S** = Stabbing	**O** - Other
** **SC =** Scars (surgical or injury induced) **		



Patient Name: _____ Date of Injury/Pain Began: _____ Today's Date: _____