

Name: _____ Date: _____ MRN: _____

General Information

Age: _____ Height: _____ Weight: _____ Surgery Date: _____
Employer: _____ Position: _____

Do you have any special needs/concerns?

(i.e. vision, hearing, speech, language, translator, physical limitations, environmental concerns, etc)

No Yes (Please list) _____

How did it start? _____

What makes it worse? _____

What makes it better? _____

Is it better, worse or the same since it began? _____

Circle the percentage of your daily activities you are able to do: 0% 25% 50% 75% 100%

List normal activities that you are unable to do or that are difficult because of this injury:

(include work, home and recreation)

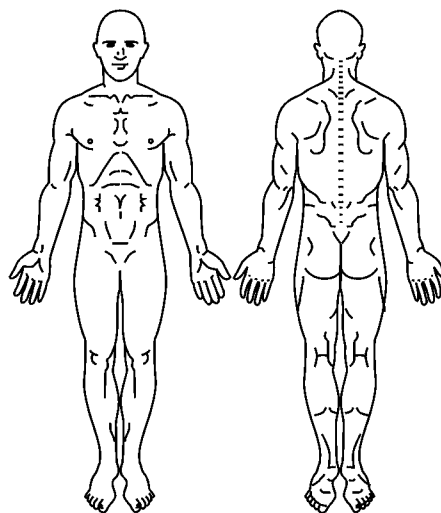
List any sports or recreational activities you would like to get back to: _____

Please describe your current symptoms using the following key.

/// = Stabbing a a a = Aching n n n = Numbness T T T = Tingling s s s = Sensitivity p p p = Other (Please describe)

Pain Intensity (please circle)

- 10 As bad as it could be
- 9 Excruciating
- 8
- 7 Severe
- 6
- 5 Moderate
- 4
- 3 Mild
- 2 Slight
- 1
- 0 No Pain



Percentage of the day you experience this level of pain? 0% 25% 50% 75% 100%

I only have pain when: _____