CURRENT HEALTH CONDITION

Name: _____. DOB: _____ Date: _____

Please circle all that apply

LOCATION: neck mid back low back

ONSET: acute (severe) chronic (had long time) gradual (occasional)

CAUSE: unknown auto related work related fall

PRIOR EPISODE: none on & off for years years ago

SIDE: left right bilateral

QUALITY OF PAIN: achy burning dull sharp stiff throbbing numbness

DESCRIPTION: mild moderate severe

HOW OFTEN DOES PAIN OCCUR: constant frequent intermittent occasional

DOES IT RADIATE: no yes -if yes, where _____

WHAT MAKES IT WORSE: activity rest

NUMBNESS: no yes- if yes, where _____

IF HEADACHES:

Location: forehead side back of head
Part of Day: morning afternoon evening
How many times per week: _____

PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

Put X's on diagram where you have pain