CURRENT HEALTH CONDITION (CON'T)

ON A SCALE OF 0-10, (10 BEING THE WORST) WHAT IS THE LEVEL OF IMPAIRMENT DUE TO SYMPTOMS **(RESTING)**:

ON A SCALE OF 0-10, (10 BEING THE WORST) WHAT IS THE LEVEL OF IMPAIRMENT DUE TO SYMPTOMS **(WITH ACTIVITY)**:

DURATION: SYMPTOM(S) STARTED:

SYMPTOM(S) WORSENED:

SYMPTOM(S) LAST OCCURRED:

SYMPTOM(S) LAST EPISODE:

INJURY OCCURRED:

ACCIDENT OCCURRED:

TIMING WORSE IN THE: ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ W/ACTIVITY ☐ CONSTANT ☐ INTERMITTENT

ASSOCIATED SIGNS & SYMPTOMS:
☐ BLURRED VISION ☐ HEADACHES ☐ STIFFNESS ☐ IN EARS
☐ DEPRESSION ☐ IRRITABILITY/MOOD SWING ☐ NAUSEA ☐
☐ DIZZINESS ☐ LOCALIZED TINGLING ☐ RINGING

QUALITY OF HEADACHES: ☐ DULL ☐ SHARP ☐ THROBBING ☐ STABBING ☐ AURA ☐ NO AURA

RADIATION: ☐ LEFT ☐ RIGHT ☐ BILATERAL
WEAKNESS: ☐ LEFT ☐ RIGHT ☐ BILATERAL

OTHER ASSOC. SIGNS & SYMPTOMS:
☐ ACHES ☐ FEVER ☐ NUMBNESS ☐ RUNNY NOSE ☐ TINGLING
☐ COLD LIMB ☐ HEARTBURN ☐ PALE BLUISH SKIN ☐ STIFFNESS ☐ VOMITING
☐ DIZZINESS ☐ MUSCLE SPASM ☐ PANIC ☐ SWEATING ☐ WEAKNESS
☐ FATIGUE ☐ NAUSEA ☐ PINS & NEEDLES ☐ SWELLING

MODIFYING FACTORS - SYMPTOMS BETTER WITH:
☐ ACTIVITY ☐ BENDING ☐ COLD ☐ HEAT ☐ MASSAGE ☐ MOVEMENT ☐ OTC MEDS ☐ RX MEDS ☐ REST ☐ STRETCHING ☐ SITTING ☐ STANDING ☐ TWISTING ☐ WALKING ☐ NOTHING HELPS

SINCE CONDITION BEGAN, HAS ANYTHING PERMANENTLY HELPED YOU? ☐ YES ☐ NO

HAS ANYTHING THAT YOU HAVE DONE, THUS FAR, FIXED YOUR PROBLEM? ☐ YES ☐ NO

EMPLOYMENT

OCCUPATION:

WORK (HRS/DAY):

JOB CLASSIFICATION: ☐ SITTING ☐ LIGHT ☐ MODERATE ☐ HEAVY LIFTING

LIFTING FREQUENCY: ☐ CONSTANT (66-100% DAY) ☐ FREQUENT (33-65% DAY) ☐ OCCASIONAL (0-32% DAY)

WORK ACTIVITY POSTURES: (HRS/DAY)
☐ SITTING ☐ STANDING ☐ WALKING ☐ CLIMBING ☐ PUSHING ☐ PULLING ☐ KNEELING ☐ REACHING ☐ TWISTING

REPETITIVE ACTIVITIES: (HRS/DAY)
☐ COMPUTER ☐ PHONE ☐ MACHINERY ☐ HAND TOOLS ☐ ASSEMBLY ☐ GRASPING

HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE:
☐ MILD PAINFUL (CAN DO) ☐ MODERATE PAINFUL (LIMITED) ☐ SEVERE (UNABLE TO PERFORM) ☐ OTHER (EXPLAIN):

DAILY ACTIVITIES: EFFECTS OF CURRENT CONDITION ON PERFORMANCE:

ACTIVITY (place a check in column applicable)	NO EFFECT	MILD PAINFUL (CAN DO)	MOD. PAINFUL (LIMITED)	SEVERE (UNABLE TO PERFORM)	ACTIVITY (place a check in column applicable)	NO EFFECT	MILD PAINFUL (CAN DO)	MOD. PAINFUL (LIMITED)	SEVERE (UNABLE TO PERFORM)
Bicycling					**Running**				
Carrying Groceries					**Self Care - Dressing**				
Change Posn-Sit-Stand					**Self Care - Shaving**				
Child Care					**Sexual Activities**				
Climb Stairs					**Sleep**				
Computer Use					**Static Sitting**				
Daily Pet Care					**Static Standing**				
Driving					**Swimming**				
Exercise					**Walking**				
Golf					**Weight LIfting**				
Household Chores					**Yard Work**				
Lift Children									
Pilates									