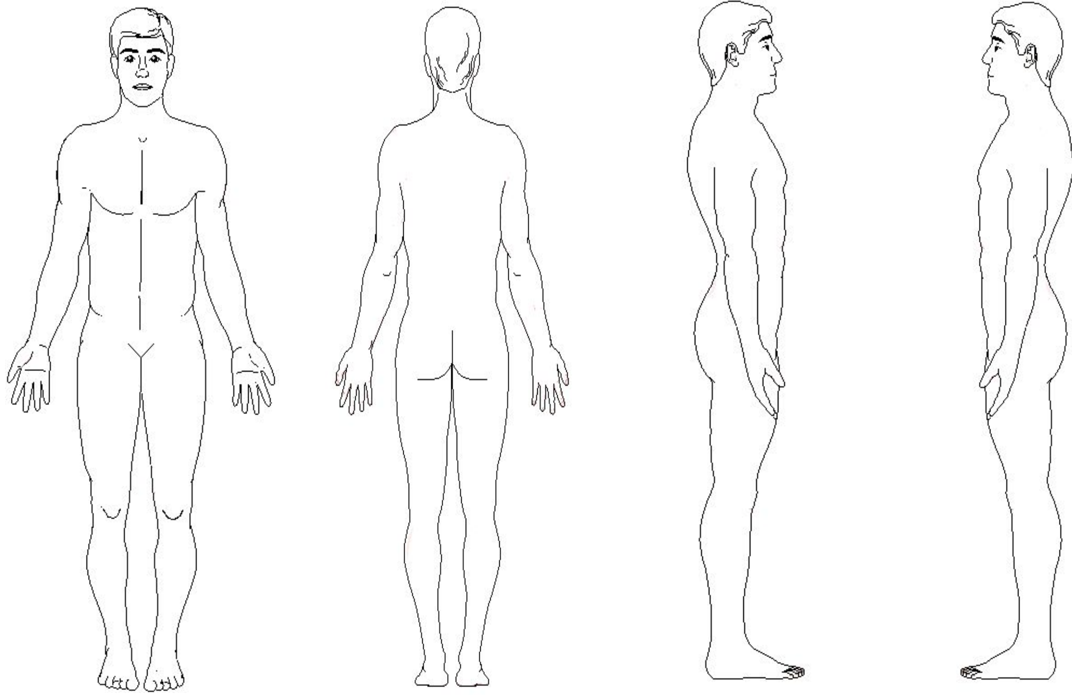
Name:____

Please mark where you are having problems on the pictures.
The Key below shows you how to mark each figure so we can better understand the problems you are having.
For example- if you are tight in your neck you mark a "T" on the neck area, etc.

KEY
T = Tight
D = Dull
S = Sharpe
N = Numb
B = Burning
ST= Stiff
TG= Tingling
SH= Shooting
TH= Throbbing
O = Other



Please indicate on a scale of 1 to 10 how severe your problem is. The definitions below the numbers will help you decide which number to circle.

1	2	3	4	5	6	7	8	9	10
No pain		mild	uncomfortable		distressing		horrible		excruciating

What caused your problem(s):____

When did this start:____

Is the pain: ☐ all the time/constant ☐comes & goes/frequent ☐once in a while/occasionally

Is the problem: ☐ getting better ☐staying the same ☐ getting worse

What activities make it worse?____

Is there a time of day the pain gets worse? ☐ yes ☐ no If yes, explain__________________________

Does it bother you when you: ☐ sit ☐ stand ☐ walk ☐ bend ☐ lay down ☐ do housework

Does it interfere with your: ☐ work ☐ daily routine ☐ recreational activities ☐ sleep

What have you done to treat the problem before today?__________________________________

____

Does anything make it better?____

PATIENT SIGNATURE (X)______________________________Date__________________

PARENT/GUARDIAN SIGNATURE(X) ___________________________Date__________________