Name Date

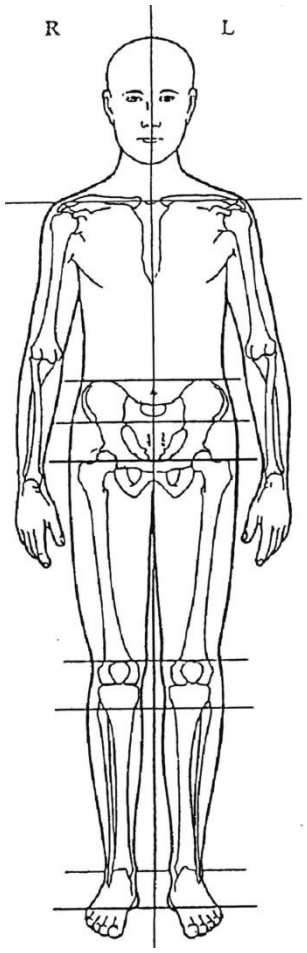
Age Occupation Sex M F

Sports/Hobbies

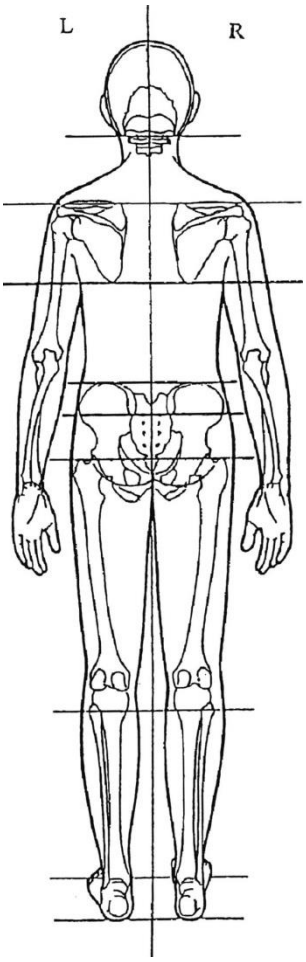
Relationship Status

Please circle on the body chart below:

1) Any areas of Symptoms/Pain/Dysfunction
2) Circle any applicable words and draw a line to the are on the body chart



Burning	Stabbing
Aching	Throbbing
Sharp	Dull
Heavy	Catching
Numbness	Pins & Needles
Tight	Weak
Unstable	Giving Way
Stiff	Loose
Deep	Superficial
Constant	Intermittent
Clicking	Clunking
Grinding	Locking
Shooting	Sciatica
Spasm	Cramping
Other	



Generally my pain is 0---1---2---3---4---5---6---7---8---9---10
No pain Worst imaginable pain

After aggravation my pain is 0---1---2---3---4---5---6---7---8---9---10
No pain Worst imaginable pain

My pain is aggravated by _____

List 3 activities/things that you can't do or have difficulty with as a result of this injury. This provides a baseline to monitor your progress.Rate your ability to do the activity on a scale out of 10.
0 means you can do it with no pain. 10 means you can't do it at all.

Can Do It/No Pain Can't Do It

1. _____ 0---1---2---3---4---5---6---7---8---9---10
2. _____ 0---1---2---3---4---5---6---7---8---9---10
3. _____ 0---1---2---3---4---5---6---7---8---9---10

1. For this current condition/injury, please circle if you have had any of the following?

X-ray CT Scan MRI Ultrasound Bone Scan Other diagnostic

Physio Osteo Chiro Acupuncture Massage GP Specialist Other

2. Have you had any previous injuries? No Yes (please give details below)

3. Do you have any pre-existing health conditions? No Yes (please give details/circle below)

Pregnant Recent Surgery Previous Surgery Asthma Epilepsy Cancer Shortness of Breath

Heart Problems Reflux Pacemaker Diabetes Double Vision Nausea Vomiting

Dizziness Fainting Blackouts Rheumatoid Arthritis Facial Pins and Needles

Osteoporosis Bladder Weakness Bowel Weakness Implants Skin Rash Ulcers Joint Replacements

Colitis IBS Fibromyalgia HIV DVT Unrelenting Pain Osteoarthritis Fainting Unexplained Weight loss

Haemophilia High Blood Pressure Ankylosing Spondylitis

4. Are you taking any medication? No Yes (please give details/circle below)

Pain Killers Anti-inflammatory Blood Pressure Medication Heart Medication Anti-depressants Thyroid medication

Kidney medication Diabetic Medication Supplements Steroids Other

Thank you for giving us the information we need to help you!