Current Problem

Today's Date ____/____/_____

Name: _____ Birthdate: _____/_____/_____

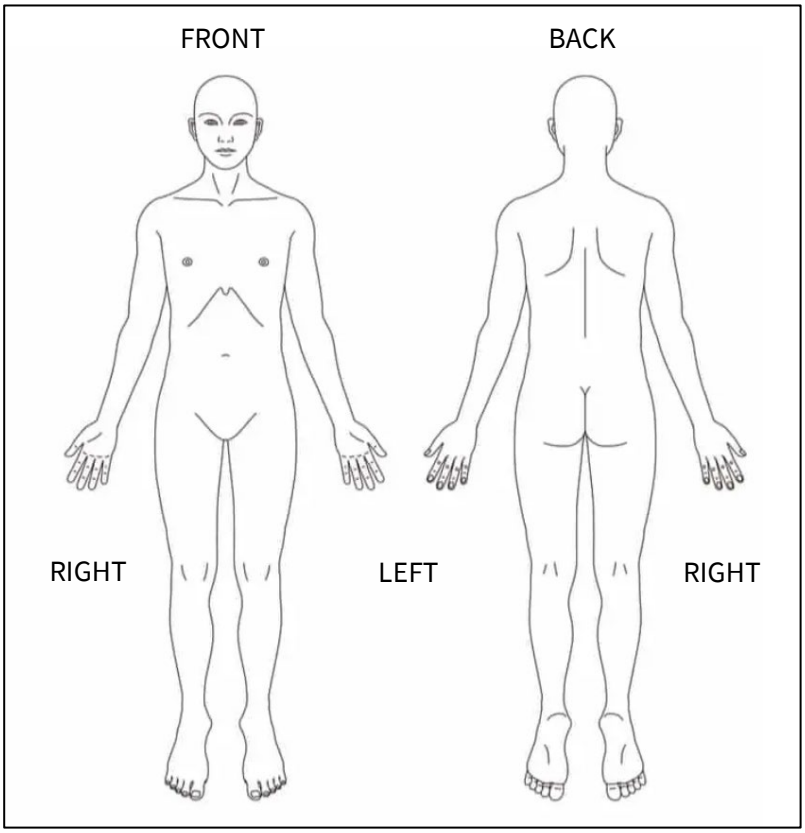
When (approximately) did your current condition/symptoms start? _____

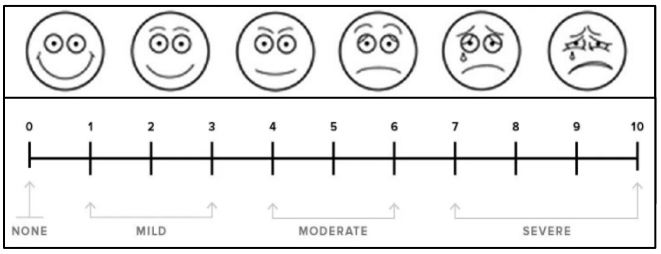
Was this due to an accident or injury? ☐ Yes ☐ No If, yes, please describe the incident briefly: _____

_____

What treatment(s) have you tried up to this point? ☐ None ☐ Medication ☐ Injection ☐ Exercise ☐ PT ☐ Chiropractic ☐ Massage ☐ Activity Change ☐ Other: _____

Mark the areas of current symptoms on the diagram below





Using the 0-10 Scale above, rate the SEVERITY of your pain…

RIGHT NOW: ____ /10

AT BEST: ____ /10

AT WORST: ____ /10

In the past 3 months have you had or regularly experienced the following: *(check all that apply)*

- ☐ Numbness
- ☐ Tingling
- ☐ Dizziness
- ☐ Double Vision
- ☐ Nausea/Vomiting
- ☐ Difficulty Speaking
- ☐ Difficulty Swallowing
- ☐ Bowel/Bladder Changes
- ☐ Fatigue/Loss of Energy
- ☐ Unexplained weight change
- ☐ Fever/Chills
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Fainting/Passing Out

Compared to when it started, my problem is… ☐ Getting Better ☐ Getting Worse ☐ The Same

List **3 activities** that are **important to you** that you are **unable** to do or you **have difficulty doing due to your symptoms/condition**:

*Next to each activity, use the scale below **(0-10)** to **rank your ability to perform that activity TODAY.***

Activity	Ability to perform (0-10)
1.	____ / 10
2.	____ / 10
3.	____ / 10

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

This is a confidential record and will be kept in your patient record. Information collected here will not be released to anyone without your authorization