Patient Name ____ **Date** _____________________

Symptom 1 ____

On a scale from 0 - 10, with 10 being the worst, please **circle the number** that best describes the symptom **most of the time:**
1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 – 10 – 15 – 20 – 25 – 30 – 35 – 40 – 45 – 50 – 55 – 60 – 65 – 70 – 75 – 80 – 85 – 90 – 95 – 100
When did the symptom begin? ____ Onset: ☐ sudden or ☐ gradual
How did the symptom begin? ____
Please identify how your current condition is affecting your ability to perform activities that are routinely part of your life:

- **Carry/Lift** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Bending/Turning** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Sitting** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Extended Computer Use** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Getting Up After Sitting** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Standing** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Walking** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Climb Stairs** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Exercise** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Sleep** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Activities of Daily Living** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Driving** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Read/Concentrate** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Other**_______________ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

What makes the symptom better? ☐ Nothing ☐ Rest ☐ ice ☐ heat ☐ stretching ☐ exercise ☐ OTC Meds ☐ Other _____________
What makes the symptom worse? ☐ Bending/Lifting ☐ Turning ☐ exercise ☐ Sitting ☐ Standing ☐ Walking ☐ Other _________
Describe the quality of the symptom: ☐ Dull ☐ Achy ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Burning ☐ Pinching ☐ Other _________
Does the symptom radiate to another part of your body**:** ☐ No ☐ Yes: ____
Is the symptom worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

Symptom 2 ____

On a scale from 0 - 10, with 10 being the worst, please **circle the number** that best describes the symptom **most of the time:**
1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 – 10 – 15 – 20 – 25 – 30 – 35 – 40 – 45 – 50 – 55 – 60 – 65 – 70 – 75 – 80 – 85 – 90 – 95 – 100
When did the symptom begin? ____ Onset: ☐ sudden or ☐ gradual
How did the symptom begin? ____
Please identify how your current condition is affecting your ability to perform activities that are routinely part of your life:

- **Carry/Lift** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Bending/Turning** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Sitting** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Extended Computer Use** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Getting Up After Sitting** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Standing** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Walking** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Climb Stairs** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Exercise** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Sleep** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Activities of Daily Living** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Driving** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Read/Concentrate** ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
- **Other**_______________ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

What makes the symptom better? ☐ Nothing ☐ Rest ☐ ice ☐ heat ☐ stretching ☐ exercise ☐ OTC Meds ☐ Other _____________
What makes the symptom worse? ☐ Bending/Lifting ☐ Turning ☐ exercise ☐ Sitting ☐ Standing ☐ Walking ☐ Other _________
Describe the quality of the symptom: ☐ Dull ☐ Achy ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Burning ☐ Pinching ☐ Other _________
Does the symptom radiate to another part of your body**:** ☐ No ☐ Yes: ____
Is the symptom worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

➢ **PLEASE LET US KNOW IF YOU NEED ADDITIONAL FORMS FOR ADDITIONAL COMPLAINTS**