INITIAL HEALTH HISTORY

FAMILY HISTORY:

Do you feel that your family history has had an affect on your current condition?
Yes ☐ **No** ☐

If yes, explain why _____

Are your parents alive? **Yes** ☐ **No** ☐

If deceased at what age? Mother _____ Cause of death? _____

Father _____ Cause of death? _____

Are your parents healthy? **Yes** ☐ **No** ☐

If not what conditions do they have? Mother _____

Father _____

Do you have brothers and sisters? **Yes** ☐ **No** ☐

How many? Brothers?_____ Ages? _____ Sisters? _____ Ages? _____

Are they healthy? Brothers **Yes** ☐ **No** ☐ Sisters **Yes** ☐ **No** ☐

If not healthy what illnesses do they have? Brothers? _____

Sisters? _____

Are they alive? **Yes** ☐ **No** ☐

If not at what ages did they die and what was the cause of death?

Brothers? Ages? _____ Cause of death? _____

Sisters ? Ages? _____ Cause of death? _____

Do you have children? **Yes** ☐ **No** ☐

How Many? _____ Boys ____ Ages_____ Girls ____ Ages _____

Are they all healthy? **Yes** ☐ **No** ☐

If not healthy, what illness do they have? _____

SOCIAL HISTORY:

What is your **occupation**?

Do you feel that your **Social History** has had an effect on your current condition? **Yes** ☐ **No** ☐

Do you drink **alcoholic** beverages? **Yes** ☐ **No** ☐

Do you use **tobacco** products? **Yes** ☐ **No** ☐

Do you use **recreational drugs**? **Yes** ☐ **No** ☐

Do you drink beverages with **caffeine**? **Yes** ☐ **No** ☐

Do you take **vitamin** supplements? **Yes** ☐ **No** ☐

Why? _____

Do you go to a **Gym or Health Club**? **Yes** ☐ **No** ☐

Why? _____

Do you drink **Bottled water**? **Yes** ☐ **No** ☐

Why? _____

PAST MEDICAL HISTORY:

Have you been to a **Chiropractor**? **Yes** ☐ **No** ☐

How Long Ago? _____ Name of Chiropractor? _____Do Not Recall☐

What were you treated for? _____

Do you have any **drug or other allergies**? **Yes** ☐ **No** ☐

What drugs? _____

Do you have any **other allergies**? **Yes** ☐ **No** ☐

What are they? _____

Other than for your current problem, have you been **hospitalized** in the past **five years**?

Yes ☐ **No** ☐

Date / / Reason

How Long ?

Have you had any other accidents? **Yes** ☐ **No** ☐

Workers Compensation? **Yes** ☐ **No** ☐

Auto? **Yes** ☐ **No** ☐

If Yes please describe:_____ _____

Describe any treatment:

Have you had any significant **health problems** in the past? **Yes** ☐ **No** ☐

If you have had any of the following health problems in the past please check any of the following that may pertain to you. If not continue to the next topic.

☐ Heart Attack	☐ Heart Surgery/Pace Maker	☐ Heart Murmur
☐ Stroke	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Hepatitis
☐ Alcohol Abuse	☐ Shingles	☐ Cancer
☐ Drug Abuse	☐ Emphysema	☐ Anemia
☐ HIV/AIDS	☐ Glaucoma	☐ Rheumatic Heart
☐ Frequent Neck Pain	☐ Psychiatric Problems	☐ Ulcers
☐ High Blood Pressure	☐ Kidney Problems	☐ Asthma
☐ Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy
☐ Severe/Frequent Headaches	☐ Difficulty Breathing	☐ Arthritis
☐ Fainting/Seizures/Epilepsy	☐ Artificial Bones/Joints	☐ Tuberculosis
☐ Lower Back Problems	☐ Diabetes	☐ Colitis

WOMEN ONLY

To the best of your knowledge are you pregnant? **Yes** ☐ **No** ☐

Have your past pregnancies been normal? **Yes** ☐ **No** ☐

If not, why? _____

I have never been pregnant. **Yes** ☐ **No** ☐

Do you consult an OB/GYN regularly? **Yes** ☐ **No** ☐

If Yes what is the OB/GYN's Name? _____

Date of Onset of yourCurrentCondition? When did it start? ___ / ___ / ___

Description of Accident/Injury/Condition?
How did it happen?

_____
_____
_____

Type: ☐ **Automobile Accident** ☐ **Slip/Fall Accident**

☐ **Pedestrian Accident** ☐ **Workmen's Compensation**

☐ **Not an Accident -Explain** _____

Were you treated by any other doctors for this condition? **Yes** ☐ **No** ☐

Name of treating doctors and Specialists:_____

Are you currently taking any medications? **Yes** ☐ **No** ☐

☐ Anti-Inflammatory ☐ Tranquilizers ☐ Insulin Injection ☐ Diabetes medication Pills

☐ Muscle Relaxants ☐ Pain Medication ☐ Antibiotics ☐ Blood Thinners

☐ Birth Control Pills ☐ Blood Pressure Medications ☐ Other List: _____

Please complete the following indicating those items that pertain to your current health:

☐ Heart Attack	☐ Heart Surgery/Pace Maker	☐ Heart Murmur
☐ Stroke	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Hepatitis
☐ Alcohol Abuse	☐ Shingles	☐ Cancer
☐ Drug Abuse	☐ Emphysema	☐ Anemia
☐ HIV/AIDS	☐ Glaucoma	☐ Rheumatic Heart
☐ Frequent Neck Pain	☐ Psychiatric Problems	☐ Ulcers
☐ High Blood Pressure	☐ Kidney Problems	☐ Asthma
☐ Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy
☐ Severe/Frequent Headaches	☐ Difficulty Breathing	☐ Arthritis
☐ Fainting/Seizures/Epilepsy	☐ Artificial Bones/Joints	☐ Tuberculosis
☐ Lower Back Problems	☐ Diabetes	☐ Colitis

Did you receive treatment in a hospital for your current condition? Yes ☐ No ☐

When did you go to the hospital? ☐ **Immediately** ☐ **Next day** ☐ **Days later** ☐ **Later that day**

How did you get to the hospital? ☐ **Ambulance** ☐ **Police** ☐ **Drove Self** ☐ **Someone else**

What hospital **emergency room** were you taken to?

Were you **admitted**? **Yes** ☐ **No** ☐ How many days were you hospitalized?

What treatment was given?

☐ **Oral Medication** ☐ **Injection** ☐ **Topical Antiseptics** ☐ **Bandages** ☐ **Sutures**

☐ **Ice Packs** ☐ **Hot Packs** ☐ **Splint** ☐ **Cast** ☐ **Brace**

☐ **Collar** ☐ **Surgery-explain**_____

Were x-rays taken? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas x-rayed?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Were MRI's performed? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Were CT scans performed? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Instructions given at discharge?

☐ no further care necessary ☐ See Chiropractor ☐ See family doctor

☐ See Physical Therapist ☐ **See Neurologist** ☐ See Orthopedist

☐ Use Ice ☐ **No Work** ☐ Take Pain medication

☐ Take Anti-inflammatory ☐ Take Tranquilizers ☐ Take Antibiotics

☐ **Use** Heat ☐ **Rest** ☐ **None**

If you had these symptoms before please describe:

DIFFICULTY IN:

☐ Bending ☐ Standing ☐ Walking ☐ Lying ☐ Reaching

☐ Lifting ☐ Twisting ☐ Coughing ☐ Sitting ☐ Sneezing

☐ Rising to walk after sitting or lying down

PAIN IS RELIEVED BY:

☐ Rest ☐ Nothing ☐ Ice ☐ Heat ☐ Sitting

☐ Aspirin ☐ Advil ☐ Standing ☐ Exercise ☐ Tylenol

SYMPTOMS ARE:

☐ Improving Slowly ☐ Improving Moderately ☐ Improving Greatly

☐ Recurrent ☐ Getting Worse ☐ Not Improving

Have you missed work due to this accident/condition? ☐ Missed No Work ☐ Limited

Work Activity ☐ Missed Work From / / to / /

I ☐ **Have** ☐ **Have Not** had these symptoms before.

I ☐ **Was** ☐ **Was Not** symptomatic prior to the start of this condition or injury.

Did you self treat your symptoms? ☐ Yes ☐ No

☐ Ice ☐ Heat ☐ Bed Rest ☐ Over-The-Counter Medication

ACTIVITIES OF DAILY LIVING GENERAL PAIN DISABILITY INDEX

The rating scales are designed to measure the degree to which several aspects of the patient's life are presently disrupted by acute or chronic pain. In other words, we determine how much the pain the patient is experiencing is preventing the patient from doing what would normally be done, or-from doing it as well as the patient normally would. Each category was responded to by indicating the overall impact of pain in the patient's life, not just when the pain is at its worst.

For each of the six categories of daily living listed, the patient write the number, which best described the typical level of activities.

A score of 0 means no disruption in functioning at all, and a score of 10 signifies that all of the activities in the specific category in which the patient would normally be involved have been totally disrupted or prevented by the pain.

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores and duties performed around the house and errands or favors for other family members (e.g., driving the children to school, Travel, Driving, Riding as a passenger, Driving for more than 15-20 minutes, Riding as a passenger for more than 15-20 minutes, Sitting, Climbing stairs, Getting in/out of auto, Kneeling, Lifting children, Using telephone, Using computer, Yard Work, Mowing lawn, Raking leaves, Gardening, Housework, Doing Laundry, Making beds, Bending, Running, Walking, Walking for long distance, Sitting for long periods of time, Lifting more than a few pounds, Vacuuming, Washing dishes, Ironing, Carrying groceries, Caring for pets, Cooking.)

The patient indicated that Family/Home Responsibilities were affected at a level of ___ .

RECREATIONAL ACTIVITIES: This category includes hobbies, Reading, Playing piano, Exercising, Swimming, sports and other similar leisure time activities.
The patient indicated that Recreation Activities were affected at a level of ___ .

SOCIAL ACTIVITY: This category refers to activities, which involve participation with friends and acquaintances other than family members, it includes parties, theater, concerts, dining out, and other social functions.
The patient indicated that Social Activities were affected at a level of ___ .

OCCUPATIONAL ACTIVITIES: This category refers to activities that are a part of our directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.
The patient indicated that Occupational Activities were affected at a level of ___ .

SELF CARE ACTIVITIES: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, Personal Grooming, Combing hair, Shaving, In/out bathtub, Brushing teeth, Getting dressed, etc.)
The patient indicated that Social Care Activities were affected at a level of ___ .

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating, sleeping, Lying in bed, Chewing, Sitting in recliner and breathing.
The patient indicated that Life-Support Activities were affected at a level of ___ .

The above Activities of Daily Living Pain Indexes totaled .

By dividing the sum total of all the Activities of Daily Living Ratings by the total of possible Total

Disability you arrive at a percentage of Total Activities of Daily Living Disability. The patient was given a Activities of Daily Living General Pain Disability Index Questionnaire on and had a score of and a percentage of General Pain Disability of % . The percentage of disability is rated 0-20%, No Disability to Minimal disability, 21-40% Moderate disability, 41-60% Severe disability, 61-80% Crippling disability, 81-100% Bed-bound or Exaggerating.

INITIAL COMPLAINTS

PAIN SCALE - BASED ON A SCALE OF 0 TO 10, WITH 10 BEING THE MOST SEVERE, PLEASE RATE EACH SYMPTOM ACCORDINGLY.

GENERAL [] Nervous [] Irritable [] Tension [] Depression [] Fatigue [] Sleeping problems

JAW PAIN: ☐ Right ☐ Left ☐ **Both Jaw Pops** ☐ Right ☐ Left ☐ ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Mild

☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

NECK PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

INCREASED BY MOVEMENT:

ROTATION ☐ Right ☐ Left

BENDING ☐ Forward ☐ Backward ☐ Right ☐ Left

☐ Neck Stiffness ☐ Muscle Spasm ☐ Grinding and Grating Sounds

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HEADACHES:

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

LOCATED:
☐ Front ☐ Back ☐ Temples ☐ Forehead ☐ Behind Eyes

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SHOULDER PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

LIMITED MOVEMENT: ☐ Right ☐ Left ☐ Both

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM PAIN: ☐ Right ☐ Left ☐ Both ☐ Forearm ☐ Upper Arms

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ELBOW ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

WRIST ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM/HAND PINS/NEEDLES:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM/HAND NUMBNESS:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM/HAND W**EAKNESS:**

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

CHEST PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

UPPER BACK PAIN: ☐ Right ☐ Left ☐ Both

SPASM ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LOWER BACK PAIN: ☐ Right ☐ Left ☐ Both

SPASM ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SACRO-ILIAC: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HIP PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

BUTTOCK PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG PAIN ☐ Right ☐ Left ☐ Both

RADIATING TO THE ☐ Knee ☐ Calf ☐ Foot

DOWN THE ☐ Front ☐ Back ☐ Side

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG/FOOT PINS & NEEDLES ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG/FOOT NUMBNESS ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG/FOOT WEAKNESS ☐ Right ☐ Left ☐ Both **in the** ☐ Thigh ☐ Calf

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

KNEE PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ANKLE PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Name (Print) _____Date / / Signature _____

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