

Patient Completes This Section

_____ _____
Last Name **First Name** **MI** **M** **F** **Date of Birth**

1) Briefly describe your symptoms: _____

2) How did your symptoms start? _____

3) My symptoms began on: _____

Date

4) Average pain intensity: (please circle)

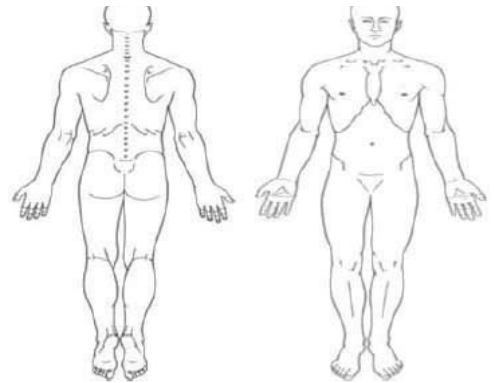
Last 24 hours: No pain 0 1 2 3 4 5 6 7 8 10 worst pain

Past week: No pain 0 1 2 3 4 5 6 7 8 10 worst pain

5) How often do you experience your symptoms?

- Constantly (76%-100% of the time) Frequently (51%-75% of the time)
 Occasionally (26%-50% of the time) Intermittently (0%-25% of the time)

Please indicate where you have pain or other symptoms:



6) How much have your symptoms interfered with your usual daily activities? (including work outside the home & housework)

- Not at all A little bit Moderately Quite a bit Extremely

7) In general, would you say that your overall health right now is...

- Excellent Very good Good Fair Poor

Provider Completes This Section

Patient Type:

- New to your office
- Est'd, new injury
- Est'd, new episode
- Est'd, continuing care

Cause of Current Episode:

- Traumatic
- Unspecified
- Repetitive
- Post-surgical
- Work related
- Motor vehicle

Date of Surgery:

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- ACL Reconstruction
- Rotator Cuff/Labral Repair
- Tendon Repair
- Spinal Fusion
- Work related
- Joint Replacement
- Other: _____

Diagnosis (ICD code)

1: _____
 2: _____
 3: _____
 4: _____

Nature of Condition:

- Initial onset (within last 3 months)
- Recurrent (multiple episodes of <3 months)
- Chronic (multiple episodes of > 3 months)

Notes:

Current Functional Measure Score:

Neck Index: DASH:
 Back Index: LEFS: Other

Patient Signature: _____

Date: _____