



920 NE 112th Av, Suite 103, Vancouver WA 98684
Phone: 360.567.2002, Fax: 360.567.2005

Date: _____

Name: _____

Age: _____

Occupation: _____

Work Status (circle): Normal Light Duty Reduced Hours Off Work

Height: _____

Weight: _____

Handedness (circle): Right Left

Referring Physician: _____

Diagnosis: _____

Date of Injury: _____

Date of Surgery: _____

What major complaint, symptom or problem brings you here?

Describe your symptoms specifically:

How did your symptoms begin, and how have they progressed?

Are your symptoms getting Better Worse Staying the Same

Are your symptoms **Constant** or **Intermittent** (circle)

If Intermittent: How often do they occur? _____

How long do they last? _____

Place three circles on the scale below to indicate the intensity of your pain on **average**, at **best**, and at **worst**.

0 1 2 3 4 5 6 7 8 9 10
No Pain.....Worst Pain Imaginable

Do you have trouble falling asleep? Yes No

Is your sleep restful? Yes No

In what position do you fall asleep? On your stomach On your back On your side

On what type of surface do you sleep? Firm Soft Sagging/Waterbed Other: _____

How many times do you awaken during the night? _____

How long before you go back to sleep? _____

What increase your pain? _____

What decrease your pain? _____

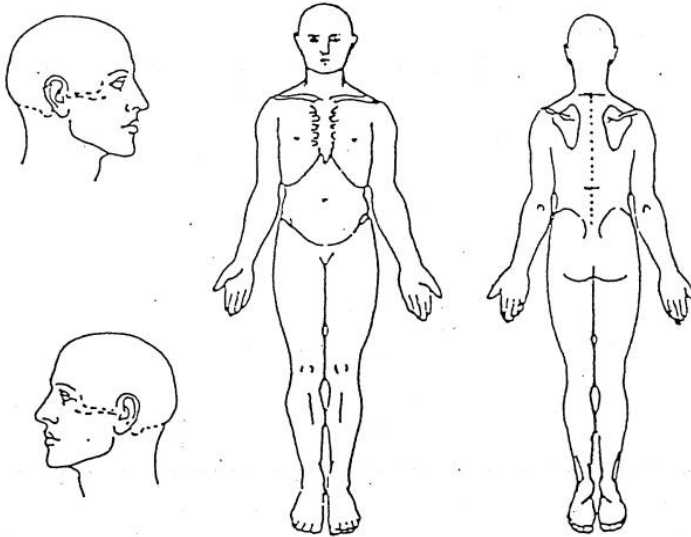
What specific activities are you unable to do because of your symptoms? _____

Please indicate the location of your symptoms:

XXX- shooting pain

---- dull pain

000-numbness



On the scale below please indicate your activity level due to your present condition as compared to your previous activity level before injury.

Inactive → Normal

On a good day: 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

On a bad day: 0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Have you seen any of the following during the past three months?

- Medical Doctor Osteopath (DO) Dentist
- Physical Therapy Chiropractor (DC) Naturopathic Doctor (ND)
- Acupuncturist Massage Therapist Other: _____

Have you had any of the following tests performed for this problem?

- X-ray MRI CT Scan Bone Scan Arthrogram Lab Tests Other: _____

Results: _____

Medications:

List all prescriptions and non-prescription medications:

Allergies:

Medications Latex Other

List: _____

Spine / Orthopedic / Bone: (circle)

Fractures dislocation sprains neck / back problem motor vehicle injury other traumas

Brief description: _____

Patient Goals:
