30 Day Pain & Function Form #_____

Name: _____ Date: _____

1. Where does it hurt and how bad? (0 no pain, 10 is worst possible pain)

Neck-Shoulder:	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Middle Back:	Right	Left	0	1	2	3	4	5	6	7	8	9	10
Lower Back/Hip:	Right	Left	0	1	2	3	4	5	6	7	8	9	10
_____ other	Right	Left	0	1	2	3	4	5	6	7	8	9	10

2. When did the most recent episode begin and why ?_____

_____

3. What does the pain feel like? Burn Ache Spasm Tight Numb _____ other

4. For each item below, please circle the number which most closely describes your condition right now. Please do not leave any blank. Circle 0 if it does not apply to you.

0= No Pain 1= Mild Pain 2= Moderate Pain 3= Severe Pain 4= Worst Possible Pain

Pain Intensity Overall	0	1	2	3	4
Sleeping (Laying down)	0	1	2	3	4
Personal Care (washing, dressing, etc.)	0	1	2	3	4
Travel (driving, sitting)	0	1	2	3	4
Work (includes house / yard work)	0	1	2	3	4
Recreation	0	1	2	3	4
Lifting	0	1	2	3	4
Walking	0	1	2	3	4
Standing	0	1	2	3	4

5. What percentage of the day are you in pain? None 25% 50% 75% 100%

6. Please Check any other issues you are having:

	Going up and down stairs		Bending over
	Reaching up		Going from sitting to standing
	Rolling over in bed		Looking over a shoulder
	Caring for your family		other: _____

Notes:

Health History Short Form #_____
Name: _____ Date: _____

Please list any medications that you currently take, including over the counter:_____

_____

_____

Please list any surgeries you have had: _____

_____

Please list any accidents or injuries you recall (auto, work, broken bones etc.): _____

_____

_____

Please check any boxes that apply to your family history:

	Cancer		Parkinson's Disease		Multiple Sclerosis
	Heart Disease / High Blood Pressure		Alzheimer's		Diabetes
	Autoimmune Disease		Arthritis		

Please check any symptoms or problems you have recently been having:

	Alzheimer's		Bowel trouble		Bladder trouble		Bleeding Issues
	Breathing Issues		Cancer		Chest / arm pain		Concentration
	Diabetes		Dizzy / Balance		Fever / Chills		Flank-Rib Pain / Kidney Stone(s)
	Heart Disease		Heart Palpitations		High Blood Pressure		Lumps / bumps
	Multiple Sclerosis		Nausea		Numbness		Night Sweats
	Parkinson's		Rapid weight gain or loss		Stomach pain		Vomiting
	Weakness						

Any other notes we should know about your past or current health status: _____

_____

_____