Self Assessment

Name:

Chief Complaint(s) / History of Present Illness					
Symptom(s)	**Side**	**Severity**	**Pain Quality**	**Date of Onset**	**Frequency**
Neck Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Middle Back Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Lower Back Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Shoulder Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Elbow Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Wrist / Hand Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Hip Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Knee Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Ankle / Foot Pain	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Other	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk
Other	❑ Left ❑ Right	❑ Mild ❑ Moderate ❑ Severe	❑ Dull ❑ Burning ❑ Sharp ❑ Tingling		❑ Constant ❑ Daily ❑ Intermittent _____/wk

- **Describe Injury / Accident:** _____

_____

_____

_____

_____

- **What treatments have you received for your complaint(s) - (Check all that apply)**

❑ None ❑ Physical Therapy ❑ Chiropractic ❑ Injection: ❑ ESI ❑ Facet ❑ Neurotomy ❑ Selective Nerve Block
❑ Medication ❑ Medical / Hospital ❑ Surgery ❑ Testing: ❑ MRI ❑ CT ❑ X-Ray ❑ Nerve Conduction

- **Name and phone number of other doctors who have treated you for your condition:** _____

_____

Current Symptoms

General

❑ Loss of Consciousness
❑ Dizziness
❑ Nausea
❑ Vomiting
❑ Visual Disturbances
❑ Ear Ringing
❑ Anxiety / Irritability
❑ Nervousness
❑ Fatigue
❑ Difficulty Sleeping
❑ Difficulty Concentrating
❑ Memory loss

Neck

Pain / Stiffness with movement:
❑ Forward bending
❑ Backward bending
❑ Turning ❑ R ❑ L
❑ Side Bending ❑ R ❑ L

Headache

❑ Migraine
❑ Forehead
❑ Back of head
❑ Temples
❑ Behind the eyes

Headache Frequency - _____ x / wk

Middle Back

Pain / Stiffness with movement:
❑ Forward bending
❑ Backward bending
❑ Turning ❑ R ❑ L
❑ Side Bending ❑ R ❑ L

Upper Extremity

❑ Numbness ❑ R ❑ L
❑ Tingling ❑ R ❑ L
❑ Weakness ❑ R ❑ L

Lower Extremity

❑ Numbness ❑ R ❑ L
❑ Tingling ❑ R ❑ L
❑ Weakness ❑ R ❑ L

Lower Back

Pain / Stiffness with movement:
❑ Forward bending
❑ Backward bending
❑ Turning ❑ R ❑ L
❑ Side Bending ❑ R ❑ L

Pain worsened with:
❑ Sitting ❑ Standing
❑ Lifting ❑ Reaching
❑ Coughing ❑ Sneezing

Other

BY SIGNING BELOW I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE.

_____ _____
Signature of Patient / Legal Guardian and Relationship to Patient **Date**

_____
Printed Name of Patient / Legal Guardian