

CURRENT CONDITION

Print Name _____

Date: _____

<p>List Two Main Areas of Discomfort:</p>	<p>1. neck / mid back / low back / _____</p> <p>Radiates where? _____</p>	<p>2. neck / mid back / low back / _____</p> <p>Radiates where? _____</p>
<p>What Happened? _____</p>		
<p>How long ago? _____ days / _____ weeks / _____ months / or DATE _____</p>		
<p>Discomfort? morning / daytime / evening / nighttime</p>		
<p>Describe Pain? dull / sharp / throb / burn / cramp / ache / tingle / numb / _____</p>		
<p>What worsens? sit / stand / walk / bend / lift / sneeze / look up/down / stairs / _____</p>		
<p>What Improves? sit / stand / walk / lie down / heat / ice / rest / medication / _____</p>		

DISCOMFORT RATING - Over the past week how would you rate the following?

Your current **Pain** or discomfort level?

No pain Worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

How much has your pain interfered with your **Daily activities**?

(housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)

No interference Unable to carry out activities
 0 1 2 3 4 5 6 7 8 9 10

How much interference with your ability to take part in recreational, **Social** and family activities?

No interference Unable to carry out activities
 0 1 2 3 4 5 6 7 8 9 10

How **Anxious** (tense, uptight, irritable, difficulty concentrating) have you been feeling?

Not at all anxious Extremely anxious
 0 1 2 3 4 5 6 7 8 9 10

How **Depressed** (down in the dumps, sad, in low spirits, unhappy) have you been feeling?

Not at all depressed Extremely depressed
 0 1 2 3 4 5 6 7 8 9 10

How has your **Work** (both inside/outside of home) been affected by your pain or discomfort?

Have made it no worse Have made it much worse
 0 1 2 3 4 5 6 7 8 9 10

How much have you been able to **Control** (reduce/help) your pain on your own?

Completely control it No control whatsoever
 0 1 2 3 4 5 6 7 8 9 10

Has your normal **Sleep** pattern been affected by your symptoms?

No trouble sleeping Unable to sleep at all
 0 1 2 3 4 5 6 7 8 9 10

Have you been able to **Walk** or stand as much as you are accustomed to?

No difficulty standing Unable to stand or walk
 0 1 2 3 4 5 6 7 8 9 10

Ability to **Lift** or carry any additional weight?

Lift heavy weight without pain Unable to carry anything
 0 1 2 3 4 5 6 7 8 9 10