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:** ____

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- **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:** ____________________

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Current Symptoms

General	Neck	Middle Back	Lower Back
❑ Loss of Consciousness	***Pain / Stiffness with movement:***	***Pain / Stiffness with movement:***	***Pain / Stiffness with movement:***
❑ Dizziness	❑ Forward bending	❑ Forward bending	❑ Forward bending
❑ Nausea	❑ Backward bending	❑ Backward bending	❑ Backward bending
❑ Vomiting	❑ Turning ❑ R ❑ L	❑ Turning ❑ R ❑ L	❑ Turning ❑ R ❑ L
❑ Visual Disturbances	❑ Side Bending ❑ R ❑ L	❑ Side Bending ❑ R ❑ L	❑ Side Bending ❑ R ❑ L
❑ Ear Ringing	**Headache**	**Upper Extremity**	***Pain worsened with:***
❑ Anxiety / Irritability	❑ Migraine	❑ Numbness ❑ R ❑ L	❑ Sitting ❑ Standing
❑ Nervousness	❑ Forehead	❑ Tingling ❑ R ❑ L	❑ Lifting ❑ Reaching
❑ Fatigue	❑ Back of head	❑ Weakness ❑ R ❑ L	❑ Coughing ❑ Sneezing
❑ Difficulty Sleeping	❑ Temples	**Lower Extremity**	**Other**
❑ Difficulty Concentrating	❑ Behind the eyes	❑ Numbness ❑ R ❑ L	
❑ Memory loss	Headache Frequency - _____ x / wk	❑ Tingling ❑ R ❑ L	
		❑ Weakness ❑ R ❑ L	

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

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

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Printed Name of Patient / Legal Guardian