Buchanan County Health Center
Here For You. Trusted For Life.

Full Legal Name _____ Age _____ Date _____

Height _____ Weight _____ Occupation _____

When did this start? _____

_____

_____

Accident related? ☐ Yes ☐ No If yes: ☐ Work Accident ☐ Car Accident

Please Indicate **LOCATION** of pain on these figures using the following marks:

QUALITY OF PAIN:

≡≡≡ Aching (dull)

●●●● Stabbing

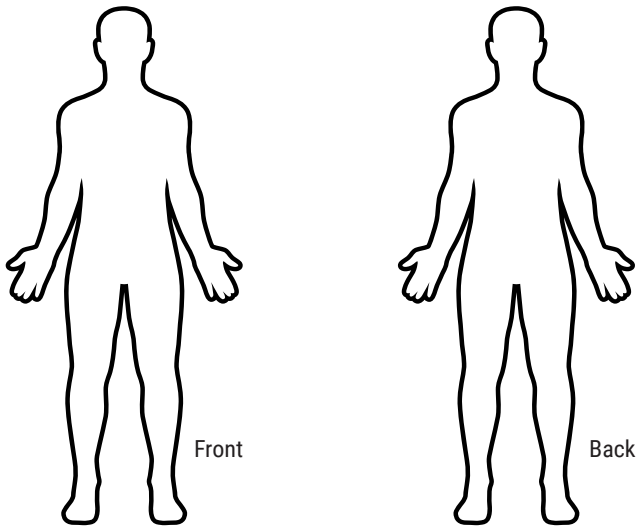
≈≈≈ Burning

xxxx Itching

((((((Numbing

Tingling

////// Radiating



Please circle the number that best describes the pain level.

0 = no pain; 1-3 = Comfortable to mild pain; 4-6 = Moderate Pain; 7-9 = Severe pain; 10 = Very severe pain, worst possible pain

0 1 2 3 4 5 6 7 8 9 10

DURATION: How long does the pain or problem last?

___Seconds ___Minutes ___An Hour ___Several Hours ___All Day

TIMING: How often does the pain or problem occur?

___Monthly ___Weekly ___Daily ___Hourly ___Constant

When do you have the most pain?

___Morning ___Evening ___Day ___Night ___Does not change

CONTEXT: Is your pain worse with:

___Coughing ___Sneezing ___Sitting ___Standing ___Walking

___Lifting ___Twisting ___Bending Forward ___Bending Backward

___At Work ___In Sports

MODIFYING FACTORS: What makes you better?

___Rest ___Activity ___Medicine: _____

___Other: _____

Are you getting: ___Better ___Worse ___No change

ASSOCIATED SIGNS AND SYMPTOMS: Do you have:

___Locking of joint ___Popping ___Catching ___Stiffness ___Weakness

___Wobbly or Unstable Joint ___Something Loose in Joint

COMPLETED BY: _____

PHYSICIAN: _____