Update From

Date: ___________________

Name: ____

Cell Phone: ________________________________ E-mail:_____________________________________

What symptoms do you want help with <u>TODAY</u>: please circle all that apply

Neck Pain   Headache   Mid Back Pain   Low Back Pain   Rt Hip Pain   Lt Hip Pain

Rt Arm Pain   Lt Arm Pain   Rt Leg Pain   Lt Leg Pain   Rt Shoulder Pain   Lt Shoulder pain

Other: ____

How did your symptoms begin: unknown, or briefly describe: ______________________________________

____

When did these symptoms begin?

Date: ________________________ or: ____________ Days ago ____________ Weeks ago ___________Months ago

What makes it worse?

____

What makes it better?

____

My pain is: Please circle: Getting Worse   Getting Better   Staying the Same

My pain is: Please circle: Constant   On/Off   Occasional

My pain level today: please circle

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

My usual level of pain is: please circle

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

The pain makes it more difficult to: please circle

Sit   Stand   Walk   Sleep   Bend Fully   Drive   Shop

Personal Care   Move without limitation   Exercise   Lift

Work without limitation   Household Chores   Other: ______________________________________

By my signature, I state my responses to be true and factual.

Signature:____

OFFICE USE: DX: _________________________ II: _________________________FC: _______________________

M99.01__________________ M99.02__________________M99.03__________________ M99.04__________________

Measurable Functional Outcome Goal: ____