

**PAIN OR INJURY FORM**

NAME \_\_\_\_\_ DATE: \_\_\_\_\_

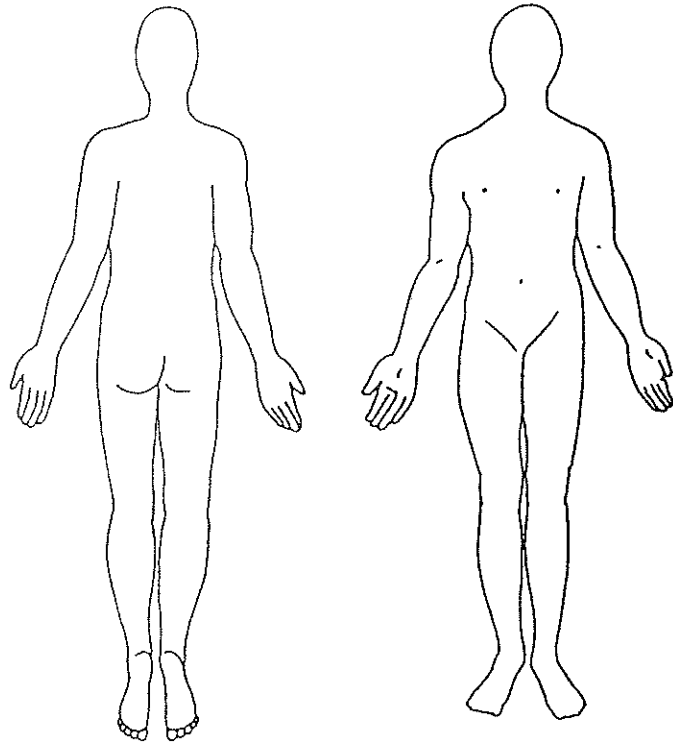
1. What are we seeing you for today \_\_\_\_\_
2. Have you had current x-rays of this area? \_\_\_\_\_ If yes what facility \_\_\_\_\_
3. Is this an injury  yes  no If yes, date of injury \_\_\_\_\_

Where did accident occur? \_\_\_\_\_  
Describe how accident or onset of pain occurred \_\_\_\_\_

**USE THE APPROPRIATE SYMBOLS TO MARK AREAS WE ARE SEEING YOU FOR TODAY**

NUMBNESS . . . PINS & NEEDLES 000  
BURNING xxx STABBING ///

ACHE \*\*\*  
On a scale from 1-10, rate your pain.  
1-slight -- 10-unbearable \_\_\_\_\_  
Does your pain limit how far you can walk?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how far can you walk before the pain makes you stop? \_\_\_\_\_  
Does your pain limit how long you can sit?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how long can you sit before the pain makes you ge out of a chair? \_\_\_\_\_  
Are you currently under a lot of stress?  
Yes \_\_\_\_\_ No \_\_\_\_\_



Have you had a previous injury to this area?  YES  NO If yes have you recovered? \_\_\_\_\_  
Is there legal action pending  YES  NO If yes attorney's name \_\_\_\_\_

TREATMENTS BY: DOCTOR  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

OTHER TREATMENTS  
PHYSICAL THERAPY \_\_\_\_\_  
CHIROPRACTIC \_\_\_\_\_  
INJECTIONS \_\_\_\_\_  
SURGERY \_\_\_\_\_

DAYS OFF WORK \_\_\_\_\_ JOB TITLE \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_