

Using the key below, indicate on the body diagrams where you are experiencing these symptoms:

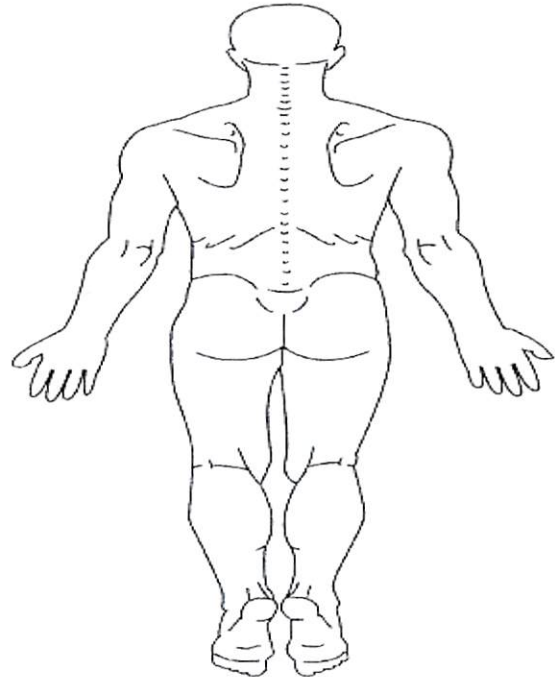
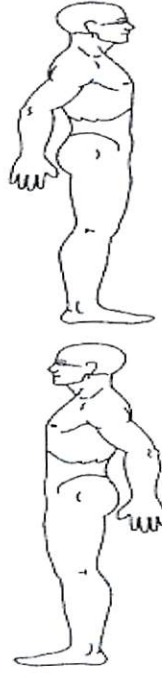
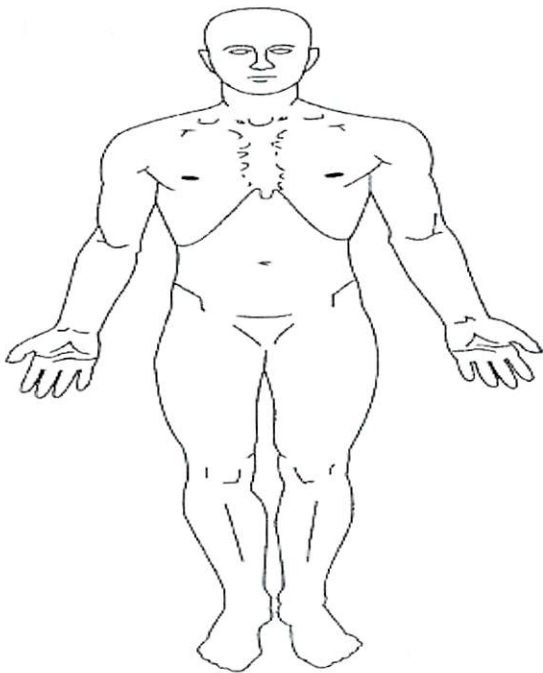
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work-related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

What describes the nature of your symptoms?

Sharp
Burning

Ache
Tingling

Numb
Throbbing

Shooting
Other _____

How are your symptoms changing? ___ getting better ___ not changing ___ getting worse

Which of the following activities of daily living are restricted / impossible for you to perform due to the nature of your condition and/or pain? (Please circle ALL that apply) If > 5, then complete ADL form.

- sleeping
- lying down
- standing
- walking
- sitting
- exercise
- vacuuming
- dusting
- lifting
- doing dishes
- gardening
- working
- driving
- eating
- bending
- hygiene
- bathing
- intercourse
- dressing
- urination

Parent/Guardian Signature: _____

Date: _____