HISTORY OF CHIEF COMPLAINT

Why would you like to be seen?

____

____

____

Were you injured at your job while working? (circle) Yes No

How did the pain begin? (circle)

Gradual Onset	Twisting	Pushing/Pulling	Bending
Direct Blow	Lifting	Vehicle Accident	Other
Recreational Accident	Fall	On-the-Job-Injury	No Known Cause
Non-work related incident			

If your pain is the result of an injury, please describe the incident: Date of accident or injury: ____________

____

____

____

Have you had previous episodes of this pain? (circle) Yes No If yes, how often ____________

Circle the *worst* and *best* times of day for your pain:

WORST	**BEST**
First Awakening	First Awakening
Morning	Morning
Mid-day	Mid-day
Afternoon	Afternoon
Evening	Evening
Nighttime	Nighttime

When is the pain most severe? (circle)

Sitting	Lifting	Coughing/Sneezing	Other: ____________
Bending	Walking	Makes no difference	____________

How often do you have to stop your activities and sit or lie down to control your pain? (circle)

Occasionally Several Times a Day Approximately once a day I spend almost all day lying or sitting to control my pain

How much of the time during an average day are you in pain?

Less then 1 hour per day
Between 1 and 4 hours per day
Between 4 and 8 hours per day
Almost any time that I am not lying down
Almost 24 hours per day

List Specific Activities which increase your pain:
1) ____________
2) ____________
3) ____________
4) ____________

Describe specific methods or activities which relieve your pain:
1) ____________
2) ____________
3) ____________
4) ____________

How would you describe your overall severity of pain? (circle)

Mild nuisance pain
Mild to Moderate, but I can live with it
Moderate, I am having difficulty dealing with it
Severe, it is ruining my quality of life
None, I have no pain

Name: ______________________________ Date of Birth: ____________