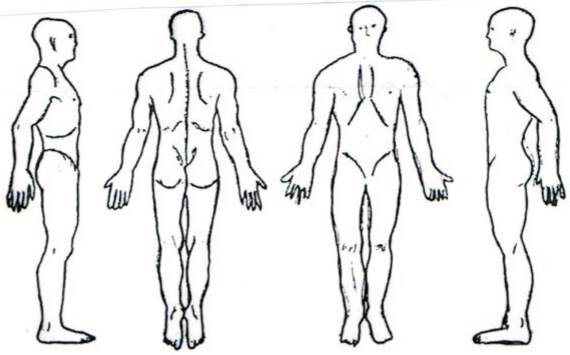
EXPLANATION OF CONDITION

Patient Name _____ **Date:** _____

Please mark areas of injury or discomfort using the key below.

KEY:
Numbness - - - -
Pins & Needles ooooo
Burning ^^^^
Aching xxxxx
Stabbing 0000



Your Chief Complaint is _____

_____

When did your problem begin? _____

Describe how your condition occurred in detail: _____

_____

Rate your pain: (Circle one) 0 No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Are you worse in the morning? ___Yes ___No

Are you worse at the end of the day? ___Yes ___No

What position(s) aggravates your condition (please circle all that apply)

Sitting **Standing** **Driving** **Walking** **Sleeping** **Sit to Stand**

Did you do anything to relieve this problem? ___Yes ___No

If yes, please explain: _____

Did you use ice? ___Yes ___No **Did you use heat?** ___Yes ___No

Have you seen any other doctors for this condition? ___Yes ___No

If so, who? _____

Have you ever experienced this condition in the past? ___Yes ___No

If yes, explain_____

How much water do you drink each day? Glasses/Bottles _____