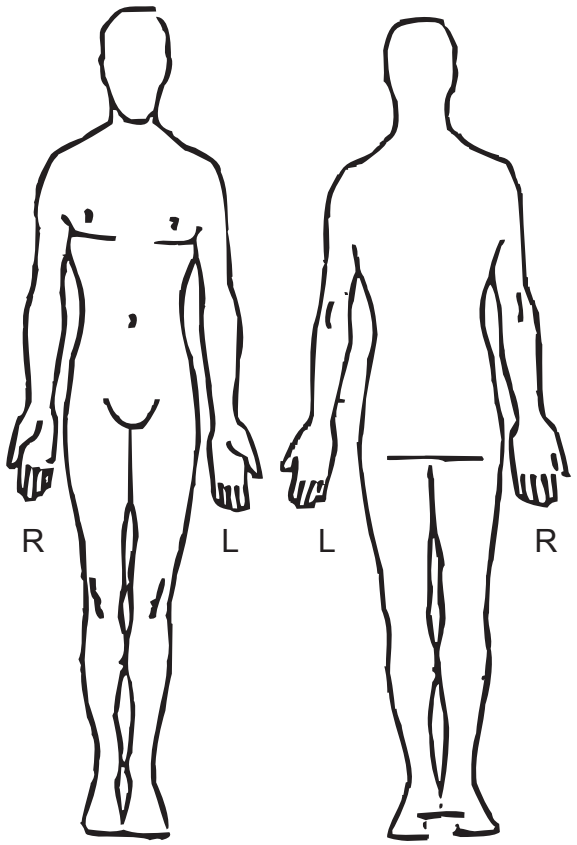
TUCSON ORTHOPAEDIC INSTITUTE

HISTORY OF PRESENT INJURY/CONDITION

1. Draw on the picture where you have the following sensations using the appropriate symbols:
   - Numbness ======
   - Pins and needles 0000000
   - Burning pain XXXX
   - Stabbing pain ///////////
   - Aching pain ^^^^^^^



2. If you are experiencing back and/or leg pain, please circle the letter that corresponds with the appropriate answer.
   - a. 100% back pain and 0% leg pain.
   - b. 75% back pain and 25% leg pain.
   - c. 50% back pain and 50% leg pain.
   - d. 25% back pain and 75% leg pain.
   - e. 0% back pain and 100% leg pain.

3. If you are experiencing neck and/or arm pain, please circle the letter that corresponds with the appropriate answer.
   - a. 100% neck pain and 0% arm pain.
   - b. 75% neck pain and 25% arm pain.
   - c. 50% neck pain and 50% arm pain.
   - d. 25% neck pain and 75% arm pain.
   - e. 0% neck pain and 100% arm pain.

4. How bad is your pain? (0 is no pain, 10 is the most excruciating pain.) Please mark the 0 to 10 scale below with an "X" to indicate how bad your pain is:

At its worst /_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/
0 5 10

Most of the time (usual) /_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/
0 5 10

At its best (least) /_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/
0 5 10

5. Please indicate how each of the following activities affects your level of pain by placing an "X" on the appropriate line.

Activity	Increases Pain	Decreases Pain	No Change in Pain
Sitting	_____	_____	_____
Standing	_____	_____	_____
Rising from sitting	_____	_____	_____
Leaning forward	_____	_____	_____
Walking	_____	_____	_____
Lying on side	_____	_____	_____
Lying on stomach	_____	_____	_____
Lying on back	_____	_____	_____
Driving	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Sleeping	_____	_____	_____

6. What medication(s) have you tried before for this pain?

_____ _____
_____ _____

7. Indicate the medication(s) you currently take or works best for your spine or extremity pain.

_____ _____
_____ _____

8. When did your present pain begin? ___/___/___

9. Please describe how you were injured or the initial onset of your symptoms.

_____
_____
_____

10. How have the symptoms of your present pain changed since the initial onset of pain? If your pain has not changed, please go to question #11.
    a. Increased. If so, where?_____
    b. Decreased. If so, where?_____

11. Is this injury work related?
    a. Yes b. No c. Not sure

12. Please indicate with a check mark whether you have had any of the following treatments and note if they were helpful or not helpful.

Treatment	**Helpful**	**Not Helpful**	**Have not had**
Physical Therapy	_____	_____	_____
Chiropractor or Osteopath	_____	_____	_____
Injections	_____	_____	_____
Other	_____	_____	_____