

Are you working? ☒ yes ☐ no If not, when did you stop? \_\_\_\_\_

Is this problem the result of an on-the-job injury? ☐ yes ☒ no

Is this problem the result of a motor vehicle accident (MVA)? ☒ yes ☐ no If yes, please check, circle one of the following:

**MVA/Driver** (E812.0) ☒

**Motorcyclist** (E810.2)

**MVA vs. Bike** (E813.6) ☒

**MVA/Passenger** (E812.1)

**Motorcycle/Passenger** (E810.3)

**MVA vs. Pedestrian** (E814.7)

**Pedestrian Hit By Car** (E812.7)

Is this problem the result of a fall? ☐ yes ☒ no If yes, please check, circle one of the following:

**At Home** (E888.8)

**Sidewalk/Curb** (E880.1)

**Snow Skis** (E885.3)

**Water Skis** (E835.4)

**Stairs** (E880.9)

**Tree** (E884.9)

**Snowboard** (E885.4)

**Chair** (E884.2)

**Ladder** (E881.0)

**Inline Skate** (E885.1)

**Commode** (E884.6)

**Scaffolding** (E881.1)

**Skateboard** (E885.2)

Which **INCREASES** your pain/discomfort? Please check or circle.

Standing *Larger Times*

Sitting *Still*

Walking

Bending forward

Bending backward

Lying on back

Lying on stomach

Lying on side

Rising from sitting

Coughing

Sneezing

Urination

Bowel movement

Which **DECREASES** your pain/discomfort? Please check or circle.

Standing

Sitting

Walking

*Phys Therapy Exercises*  
*Low Impact*  
Bending forward

Bending backward

Lying on back

Lying on stomach

Lying on side

Rising from sitting

Coughing

*Angel Stretches*

Sneezing

Urination

Bowel movement

What is the approximate amount of time you can perform the following activities?

Sit \_\_\_\_\_ minutes

Stand \_\_\_\_\_ minutes

Walk \_\_\_\_\_ minutes

Please check all of the treatments you have tried for your pain and then check the appropriate column:

	Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
<input checked="" type="checkbox"/>	Physical/Occupational Therapy	<i>Feb-22 - To Present</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	Heat/Ice		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Traction	<i>Neck 04/01</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Injections (back or neck only)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	TENS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Ultrasound		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Brace or collar		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Massage	<i>Chair</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Psychotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Chiropractic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>