Primary Care /General Doctor: _ Date of Onset of Pain: Pain Status: □ New Injury What is your primary concern? _ Pain Location:			Date of Injury: □ Chronic Injury				Height: Weight:				
Pain Scale:				0= None		5= Moderate		10= Extreme			
	0	1	2	3	4	5	6	7	8	9	
At worst:											
Current:											
At best:											
Aggravating Factors:		_		☐ Standing☐ Reaching		Пν	/alking	□ Lvin	a down		
Aggravating F	actors:			_		_		_	-	_	
			□ Sta	irs – up	□ Read	ching	□Lif	ting [ີ Gettinį	g up fro	m
Aggravating F What makes History of Sin	it feel be	etter?	□ Sta	irs – up	□ Rea	ching	□Lif	ting [worse?	☐ Getting	g up fro	m
What makes	it feel be nilar Sym Care:	etter? nptoms:	□ Sta	No 🗆 Y	□ Read	ching History	□Lif Feel w	ting [worse?	☐ Getting	g up fro	m — Io
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Patient Signature_______Date_____