FUNCTION FIRST
SPINE & SPORT

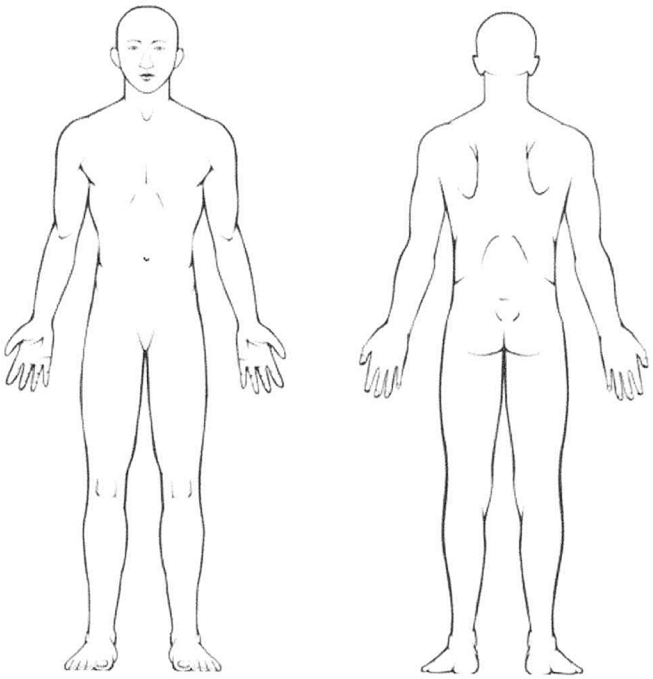
Name:_____

DOB:_____

Date:_____

Chief Complaint

Please circle on the body below where you are experiencing the pain or discomfort.
Draw arrows of any shooting pain down arms or legs and etc.



Right Left Left Right

Please rate your pain 0/10, with pain being the worst: _____/10.

This complaint came on: ☐Gradually ☐Immediately

Pain is: ☐Improving ☐Staying the same ☐ Getting worse

Frequency of pain: ☐Occasional ☐Frequent ☐Constant

The pain is: ☐Dull ☐Aching ☐Tingling ☐Throbbing ☐Burning ☐Sharp ☐Shooting

What activites make it worse:☐Laying down ☐Sitting ☐Standing ☐Walking ☐Bending over

☐Sneezing ☐Reaching ☐Squatting ☐Pulling ☐Lifting ☐Twisting ☐Coughing

☐Gripping/holding objects ☐Athletics, Explain:_____

What activites relieve the pain: ☐Laying down ☐Sitting ☐Standing ☐Walking ☐Lifting
☐Twisting ☐ Gripping/holding object

Can you go to sleep without problems? ☐Yes ☐ No

Do you awaken because of pain? ☐Yes ☐ No

Did you have sleep problems before? ☐Yes ☐ No

Fill out if you know:

Height:_____	Weight:_____	Blood Pressure:_____	Pulse:_____	Temperature:_____