PAIN SHEET		GENERAL EVALUATION Height_____Weight_____

Patient Name: Account#: DOB:

Referring Provider: Appointment Date:

Reason you went to your doctor?_____

Is this the first time we are seeing you for this injury? YES NO Date of 1st Visit:_____

What caused the problem? CAR ACCIDENT WORK INJURY FALL OTHER:_____
Location on body of your injury(be specific):_____

How long have you had pain:_____

Describe your pain: BURNING SHARP DULL ACHY SORENESS CONSTANT SEVERE

Have you had surgery on this area?: YES NO What type:_____Date_____

Where were you when you were injured?(be specific):_____
What activity where you performing when you became injured?_____

Do you have: SWELLING LUMPS MASSES Where?_____

ARM: RIGHT LEFT BOTH : PAIN NUMBNESS WEAKNESS TINGLING

LEG: RIGHT LEFT BOTH: PAIN NUMBNESS WEAKNESS TINGLING

Does anything make the pain worse? STANDING LAYING DOWN WALKING RUNNING SITTING

STATUS: WORKING FOR INCOME/ STUDENT/ MILITARY/ LEISURE/VOLUNTEER/ RETIRED/ DISABLED

MVA (circle one)	**WORKER COMP**
The accident was: OVERTURNED VEHICLE NO COLLISION / COLLISION WITH STATIONARY OBJECT COLLISION WITH RAILWAY VEHICLE COLLISION WITH ANOTHER VEHICLE(type_____) COLLISION WITH PEDESTRIAN OR ANIMAL **Date of Injury_____** **I WAS THE:** DRIVER PASSENGER PEDESTRIAN **I WAS IN A:** CAR VAN PICK UP SUV BUS MOTORCYCLE 18-WHEELER OTHER_____	Where did injury occur?_____ Date of Injury_____ What were you doing when you were injured? _____ _____