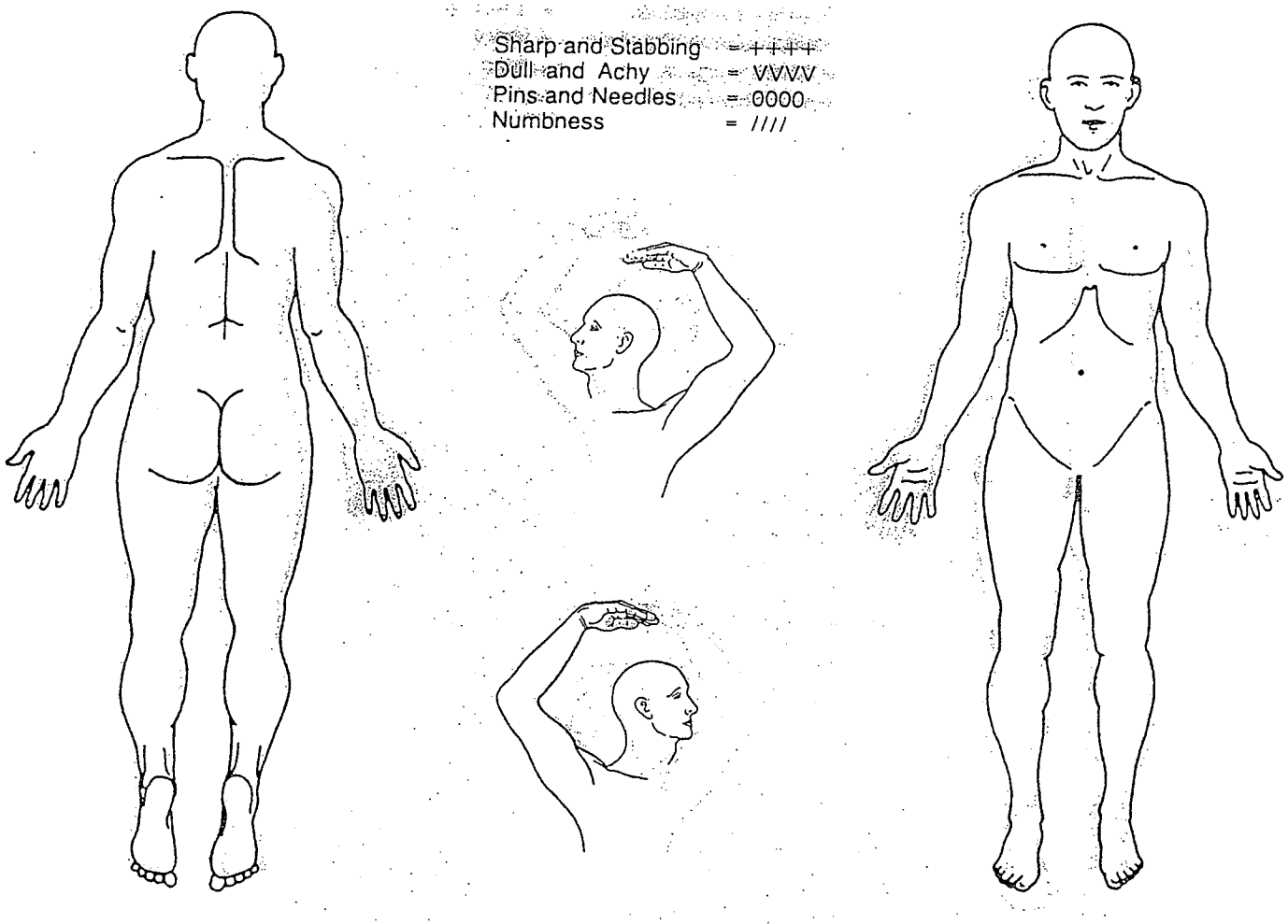
ANALOGUE PAIN SCALE

Name _____ Date _____

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.



Please check the appropriate # to describe your present pain level:
With 0 being Normal/or no pain; and 10 being very severe pain.

C = CONSTANT
I = INTERMITTENT

Area of pain	Normal	Mildly in pain			Moderate pain			Severe pain				
Neck	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Middle back	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Lower back	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Hip(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Shoulder(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Arm(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Legs Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Headaches	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Other:	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Other:	☐ 1	2	3	4	5	6	7	8	9	10	C	I
Other:	☐ 1	2	3	4	5	6	7	8	9	10	C	I

#2007-N
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Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travelling (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any Distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score

_____ / 40

For Provider Use Only

Name _____ Date _____

4765 Hoen Ave. Santa Rosa, CA 95405 Ph (707)523-3020 Fax (707)581-1943 info@summerfieldchiropractic.com

Patient Basic Information

Personal Information:

First Name:

Last Name:

Middle Initial:

Address:

City, State, Zip:

Home Phone: Work Phone:

Social Security No:

Date of Birth:

Date of Injury/Onset:

Dominant Hand: O Right O Left O Both

Insurance Information:

Policy Holder (if different than patient):

Policy No: Claim No:

Description of Accident/Injury/Onset

If this is an automobile accident, you can use the MVA Section.

During and after accident details

Enter details of your condition during and after the injury/onset.

Automobile Accident Description

Your Vehicle Type:
OCar OS.U.V. OVan OBus
OLarge Truck OPickup Truck

Other Type:

Your Position in Vehicle
ODriver OFront Passenger
O L.Rear Passenger O R.Rear Passenger

Other Position:

Time/Speed/Damage
Time of Accident: Your Speed
Their Speed

Damage to your vehicle:
OMild OModerate OTotaled

What was your vehicle doing at time of accident?
O Stopped at intersection O Stopped in traffic O Stopped at a light
O Making a right turn O Making a left turn O Parking
O Proceeding along O Slowing down O Accelerating

Other:

Details of Accident:

Visibility at the time:
O Good O Fair O Poor

Road Conditions at Time of Accident:
O Icy O Wet O Sandy
O Dark O Clean & Dry

Point of Impact:
O Head-On O Rear-End
O Left front O Right front
O Left rear O Right rear

Other:

Who hit who/what:
O You hit other vehicle
O Other vehicle hit you
You hit....(Type in object below)

Other:

Additional Accident Information:

In the case of a motor vehicle accident, write any additional info here.

During the Accident:

Body Position, etc.
Did you see the accident coming?..... Yes ☐☐ No
Were you braced for the impact?.....Yes ☐☐ No
Did you have a seat belt on?..... Yes ☐☐ No
Did you have a shoulder harness on? Yes ☐☐ No
Did the driver's front air bag deploy?.. Yes ☐☐ No
Did passenger front air bags deploy? Yes ☐☐ No
Did the side air bags deploy?..... Yes ☐☐ No
Does your vehicle have headrests?... Yes ☐☐ No

Headrest Position?
O Even with top of head
O Even with bottom of head
O Even with middle of the neck

What was the direction of the head at the time of impact?
O Facing straight forward O Turned to the right O Turned to the left

Did your body strike the inside of your vehicle?.....Yes ☐☐ No

If Yes, describe:

Did you lose consciousness during the injury?.....Yes ☐☐ No

If Yes, for how long?

Your vehicle's Estimated Damage:

Damage to their vehicle:
O Mild O Moderate O Totaled

Did police show up at the scene? Yes ☐☐ No

Was an accident report filled out? Yes ☐☐ No

Emergency Room?
Where did you go after the accident?
O Home O Work
O Hospital ER O Private doctor

How did you get there?
O Drove Self O Ambulance
O Somebody Else O Police

X-rays done? Yes ☐☐ No

Was lab work done? Yes ☐☐ No

Body parts X-rayed?

What lab work?

The x-rays revealed..

Treatments: ☐ Cervical Collar ☐ Ice Other

Medications:

Follow-up Instructions:

After the Accident:

Check off the symptoms right after and a few days following the accident.

☐ Headache ☐ Loss of smell ☐ Tension ☐ Loss of taste ☐ Diarrhea
☐ Neck pain ☐ Dizziness ☐ Irritability ☐ Toe numbness ☐ Depression
☐ Neck stiffness ☐ Nausea ☐ Mid back pain ☐ Constipation ☐ Anxious
☐ Fainting ☐ Confusion ☐ Low back pain ☐ Cold hands ☐ Chest pain
☐ Ringing in ears ☐ Fatigue ☐ Nervousness ☐ Cold Feet
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems

Others:

Doctor's Additional Data on This Patient

NOTE: This will be entered into the chart, but will not appear in Reports

Patient's Signature: Date: