Duke Chiropractic

Patient Pain Form

Please circle on this line the level or intensity of pain that you are presently experiencing:

Absolutely pain free ___ 1 2 3 4 5 6 7 8 9 10 ___ Worst pain you could ever have

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.
Mark the areas of radiation. **Include all affected areas**.

Numbness	Dull Ache	Hot Burning	Sharp Stabbing	Pins + Needles
= = =	000	XXX	/ / /	+ + +

(Other discomfort ______________________________ use * * *)

Doctors Notes:

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Updated Dx:

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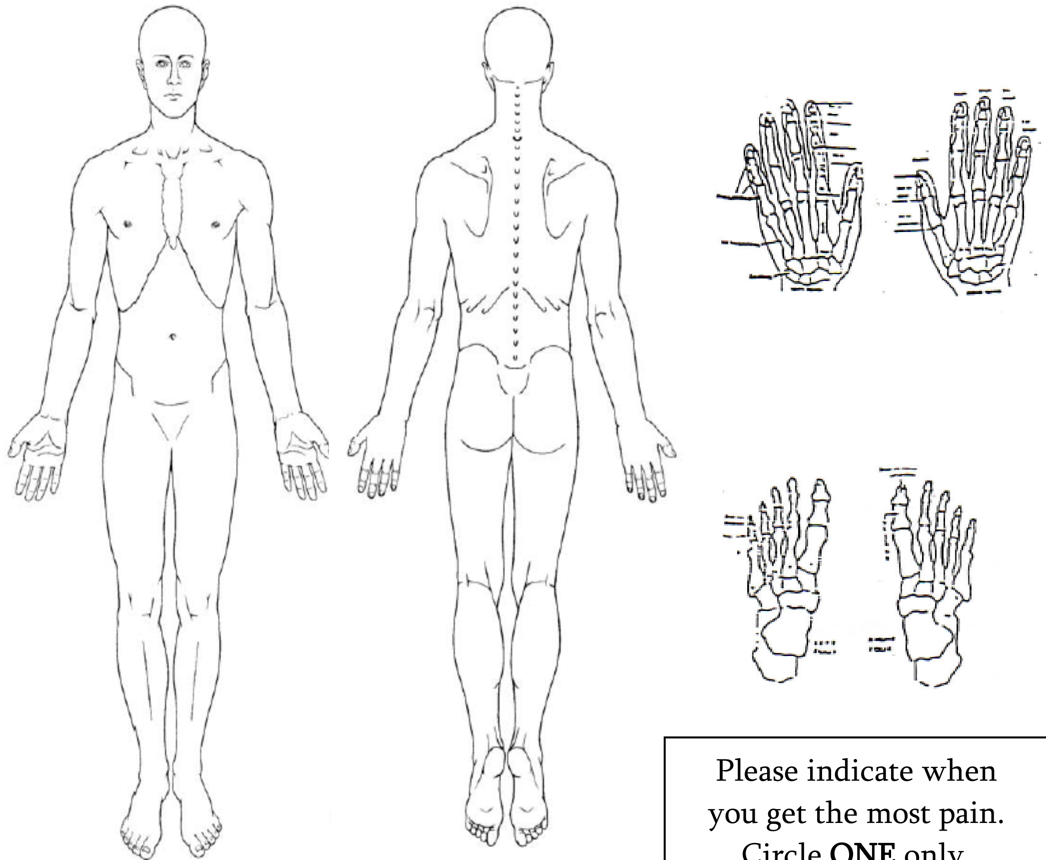

Please indicate when you get the most pain.
Circle **ONE** only.

Sitting
Standing
Lying Down
Other: ____________

Signed: ____

Date: ____

Please Continue on Reverse Side:

Activities of Daily
Living Impairment

Dear Patient:

Please be aware that the purpose of this examination is to determine your level of impairment. Impairment is defined as the loss of, loss of use of or derangement of any part, system or function. Disability is the limiting loss or absence of the capacity of an individual to meet personal, social or occupational demands, or to meet statutory or regulatory requirements.

Please read the following directions and complete the impairment check list. In terms of a normal day where you are active 16 hours and sleep 8 hours, "occasionally" means 33% impaired, "frequently" means 34 – 66% impaired and "continuously" means 67 – 100% impaired. Please mark how the specific injury or injuries you are being examined for now impair your life in a normal day.

Avtivities of Daily Living:	*How Impaired Are You?*			
	Not at All	Occasionally	Frequently	Continuously
Self Care	( )	( )	( )	( )
Normal living postures (sitting, standing, lying down etc.)	( )	( )	( )	( )
Travel	( )	( )	( )	( )
Sexual Function	( )	( )	( )	( )
Social and recreational activities	( )	( )	( )	( )
Communication	( )	( )	( )	( )
Ambulation (moving around)	( )	( )	( )	( )
Non-specified hand activities	( )	( )	( )	( )
Sleep	( )	( )	( )	( )
Writing	( )	( )	( )	( )
Work	( )	( )	( )	( )
Other:________________________	( )	( )	( )	( )

Signature: ____ Date: ______________________