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 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

 Areas of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Pain Intensity 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 NO INTERMITTENT MILD MODERATE SEVERE WORST

 PAIN PAIN PAIN PAIN PAIN POSSIBLE PAIN

1. Sleeping 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 PERFECT INTERMITTENTLY MILDLY MODERATELY GREATLY TOTALLY

 SLEEP DISTURBED DISTURBED DISTURBED DISTURBED DISTURBED

 3. Personal Care 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

(washing, dressing, etc.) NO PAIN INTERMITTENT MILD PAIN MODERATE PAIN STRONG PAIN SEVERE

 NO SOME NEED TO NEED SOME NEED 100% PAIN

 RESTRICTIONS RESTRICTIONS GO SLOWLY ASSSSTANCE ASSISTANCE

4. Travel 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 (driving etc.) NO PAIN INTERMITTENT PAIN MILD PAIN MODERATE PAIN MODERATE PAIN SEVERE PAIN

 ON LONG ON LONG ON LONG ON LONG ON SHORT ON SHORT

 TRIPS TRIPS TRIPS TRIPS TRIPS TRIPS

5. Work 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 CAN DO USUAL CAN DO USUAL CAN DO 75% CAN DO 50% CAN DO 25% CANNOT WORK

 WORK; PLUS WORK; NO OF USUSAL OF USUAL OF USUAL

 UNLIMITED EXTRA EXTRA WORK WORK WORK WORK

6. Recreation 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 CAN DO CAN DO CAN DO CAN DO A CANNOT DO

 ALL ACTIVITIES MOST ACTIVITIES SOME ACTIVITIES FEW ACTIVITIES ANY ACTIVITIES

7. Frequency of Pain 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 NO OCCASIONAL PAIN OCCASIONAL PAIN INTERMITTENT PAIN FREQUENT PAIN CONSTANT PAIN

 PAIN 10% OF DAY 25% OF DAY 50% OF DAY 75% OF DAY 100% OF DAY

1. Lifting 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 NO PAIN WITH INTERMITTENT PAIN ↑ PAIN WITH ↑ PAIN WITH ↑ PAIN WITH ↑PAIN WITH

 HEAVY WEIGHT WITH HEAVY WEIGHT HEAVY WEIGHT MODERATE WEIGHT LIGHT WEIGHT ANY WEIGHT

9. Walking 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 NO PAIN ↑ PAIN AFTER ↑ PAIN AFTER ↑ PAIN AFTER ↑PAIN AFTER ↑ PAIN WITH

 ANY DISTANCE LONG DISTANCE I MILE AFTER ½ MILE AFTER ¼ MILE ALL WALKING

10. Standing 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 NO PAIN AFTER ↑ PAIN AFTER ↑ PAIN AFTER ↑ PAIN AFTER ↑PAIN AFTER ↑PAIN WITH

 SEVERAL HOURS SEVERAL HOURS 2 HOUR 1 HOURS ½ HOUR ANY STANDING

11.Other:\_\_\_\_\_\_\_\_\_\_\_ 0\_\_\_\_\_\_\_2\_\_\_\_\_\_\_4\_\_\_\_\_\_\_6\_\_\_\_\_\_\_8\_\_\_\_\_\_\_10

 NO PAIN AFTER ↑ PAIN AFTER ↑ PAIN AFTER ↑ PAIN AFTER ↑PAIN AFTER ↑PAIN WITH

 SEVERAL HOURS SEVERAL HOURS 2 HOUR 1 HOURS ½ HOUR ANY STANDING

Patient Signature: \_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Dr. Initials: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_