Katie Holstein, D.C., 325 Water St., Toms River, NJ 08753
732-569-3241

Patient Name: _____ Date: _____

Areas of Pain: _____

1. Pain Intensity

0	2	4	6	8	10
NO PAIN	INTERMITTENT PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN

2. Sleeping

0	2	4	6	8	10
PERFECT SLEEP	INTERMITTENTLY DISTURBED	MILDLY DISTURBED	MODERATELY DISTURBED	GREATLY DISTURBED	TOTALLY DISTURBED

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

0	2	4	6	8	10
NO PAIN NO RESTRICTIONS	INTERMITTENT SOME RESTRICTIONS	MILD PAIN NEED TO GO SLOWLY	MODERATE PAIN NEED SOME ASSSSTANCE	STRONG PAIN NEED 100% ASSISTANCE	SEVERE PAIN

4. Travel (driving etc.)

0	2	4	6	8	10
NO PAIN ON LONG TRIPS	INTERMITTENT 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	2	4	6	8	10
CAN DO USUAL WORK; PLUS UNLIMITED EXTRA	CAN DO USUAL WORK; NO EXTRA WORK	CAN DO 75% OF USUSAL WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORK

6. Recreation

0	2	4	6	8	10
CAN DO ALL ACTIVITIES		CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITIES	CANNOT DO ANY ACTIVITIES

7. Frequency of Pain

0	2	4	6	8	10
NO PAIN	OCCASIONAL PAIN 10% OF DAY	OCCASIONAL PAIN 25% OF DAY	INTERMITTENT PAIN 50% OF DAY	FREQUENT PAIN 75% OF DAY	CONSTANT PAIN 100% OF DAY

8. Lifting

0	2	4	6	8	10
NO PAIN WITH HEAVY WEIGHT	INTERMITTENT PAIN WITH HEAVY WEIGHT	↑ PAIN WITH HEAVY WEIGHT	↑ PAIN WITH MODERATE WEIGHT	↑ PAIN WITH LIGHT WEIGHT	↑PAIN WITH ANY WEIGHT

9. Walking

0	2	4	6	8	10
NO PAIN ANY DISTANCE	↑ PAIN AFTER LONG DISTANCE	↑ PAIN AFTER I MILE	↑ PAIN AFTER AFTER ½ MILE	↑PAIN AFTER AFTER ¼ MILE	↑ PAIN WITH ALL WALKING

10. Standing

0	2	4	6	8	10
NO PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER 2 HOUR	↑ PAIN AFTER 1 HOURS	↑PAIN AFTER ½ HOUR	↑PAIN WITH ANY STANDING

11.Other:_____ 0_____2_____4_____6_____8_____10

NO PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER 2 HOUR	↑ PAIN AFTER 1 HOURS	↑PAIN AFTER ½ HOUR	↑PAIN WITH ANY STANDING

Patient Signature: _____ Date: _____ Dr. Initials: _____ Date: _____