OUCH

ACCIDENT
ACHES
ALLERGIES
BUMPS
COLDS
CONSTIPATION
FALLS
FATIGUE
HEADACHES
INDIGESTION
NERVOUSNESS
SELF-ADMINISTERED TREATMENT
SLEEPLESSNESS
STIFFNESS
STOMACH TROUBLE
TENSION

FORM

# CHANGE OF CONDITION REPORT

If you have experienced a sudden change in your physical condition, we would like to know about it because we want your treatment to be the best possible for your present state. Your complete recounting of any discomfort you have felt, even if you experienced no apparent reaction, will help us to help you more. Please provide us with the information requested below.

Name:_____ Date: _____

**Have you had a change in your insurance or personal information since your last visit? Please let the front desk know of any changes.**

List any falls, accidents, or other injuries you have had since your last visit: _____

_____

Date of injury:_____ Time:_____

Where did it happen? _____

_____

What happened? _____

_____

List any unusual pains, discomforts, or other symptoms you have experienced as a result of this injury or since your last visit: _____

_____

_____

What have you done to try to relieve your symptoms?

_____

_____

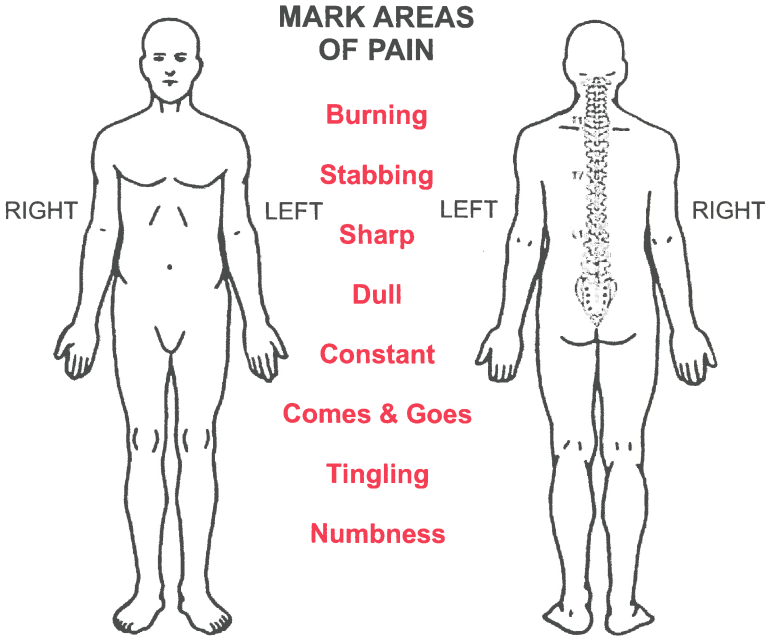
Have you received any other care for this injury? If so, where and what? _____

_____

_____

**PLEASE COMPLETE OTHER SIDE**

Please mark areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas.




## Daily Activities: Effects of Current Condition on Performance

| | | | | |
|---|---|---|---|---|
| Carrying Groceries | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Changing Positions | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Sit to Stand | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Climbing Stairs | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Pet Care | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Driving | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Extended Computer Use | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Household Chores | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Lifting Children | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Reading/Concentration | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Self Care - Bathing | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Self Care - Dressing | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Self Care - Shaving | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Sexual Activities | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Sleep | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Sitting Still | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Standing Still | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Yard Work | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |
| Walking | ❑ No Effect | ❑ Painful (can do) | ❑ Painful (limits) | ❑ Unable to Perform |