

Analysis Information:

What regular activities do you perform?	Sitting	Standing	Walking	
Running	Driving	Lifting	Bending	Squatting
Climbing	Crouching	Kneeling	Pushing/Pulling	Crawling
Maintain awkward position		Reaching above shoulders		

How much do you regularly lift?	Little to none	1 to 10 pounds	
10 to 20 pounds	20 to 40 pounds	40 to 60 pounds	60 to 80 pounds
80 to 100 pounds	Over 100 pounds		

Do you regularly bend over while lifting? Yes No

Are your hands subject to any of the listed below repetitive movements?

Light grasping (left hand)	Light grasping (right hand)	Light grasping both hands
Firm grasping (left hand)	Firm grasping (right hand)	Firm grasping both hands
Typing	Using a computer mouse or trackball	

How many hours are you required to regularly perform each of the following activities?

Sitting:	1-2 hours	2-4 hours	4-6 hours	6-8 hours
Standing:	1-2 hours	2-4 hours	4-6 hours	6-8 hours
Walking:	1-2 hours	2-4 hours	4-6 hours	6-8 hours
Lifting:	1-2 hours	2-4 hours	4-6 hours	6-8 hours

Check below if yes:

Did you report this injury in writing?
 Have you seen another health care provider since the accident?

Describe any symptoms

During the accident: _____

Immediately after the accident: _____

Later that day: _____

Next day or later: _____

What are your present complaints and symptoms:

Since this injury occurred are your symptoms
Improving

Getting worse

Same

Please check symptoms you have noticed since the accident:

Headache	Irritability	Numbness in toes	Face flushed	Vomiting
Neck pain	Chest pain	Difficulty breathing	Buzzing in ears	Nausea
Neck stiffness	Dizziness	Fatigue	Loss of balance	Stomach upset
Sleeping problems	Depression	Head seems heavy	Fainting	Constipation
Back pain	Tension	Memory loss	Fever	Diarrhea
Vision problems	Cold feet	Loss of taste	Cold sweats	Nervousness
Ringing in ears	Cold Hands	Loss of smell	Difficulty swallowing	Pins & needles in arms

Were you on any medications at the time of the accident? Yes No

If so, what medications? _____

Did you take any medications after the accident? Yes No

If so, what medications? _____

Have you lost any time from work as a result of this accident? Yes No If yes, please complete the following:

Last day worked: _____

Have you noticed any activity restrictions as a result of this injury? Yes No

If yes, please describe in detail: _____

Other pertinent information: _____

Upper and Lower Back:

Do you have upper back pain? Yes No If yes, is there scapular pain? Yes No If yes, Right Left

Do you have lower back pain? Yes No If yes, is there stiffness? Yes No

What is the pain aggravated by? _____

Do you have any restriction of motion? Yes No

Due to the back pain, do you experience any of the following? If yes, please describe the pain.:

Radiating pain: _____

Hip pain, right or left: _____

Thigh pain, right or left: _____

Knee pain, right or left: _____

Ankle or foot pain, right or left: _____

Upper Extremities: Check all that apply

Shoulder	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Arm	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Elbow	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Forearm	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Wrist	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Hand	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Fingers	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Chest pain	Right	Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9

Lower Extremities: Check all that apply

Hip	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Thigh	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Knee	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Ankle	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Foot	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9

Patient Signature

Date