

INITIAL SELF-EVALUATION FORM

Name _____

Date _____

Present Condition - Pain or Tension:

1. Please list each symptom that you are experiencing and rate each on a scale of 0-10. (Key: 10 being the most severe pain you have ever experienced)

Symptoms:

Severity:

a. _____

0 1 2 3 4 5 6 7 8 9 10

b. _____

0 1 2 3 4 5 6 7 8 9 10

c. _____

0 1 2 3 4 5 6 7 8 9 10

2. Have your symptoms: become worse become better remained the same?

3. How often do you experience your symptoms/pain? _____

4. When and what do you think initially caused your symptoms/pain? Why? _____

5. What makes your symptoms worse?

sitting lifting standing bending

other please specify? _____

6. What eases your symptoms? _____

7. How much does your symptoms interfere with your activities?

none (1-20%)

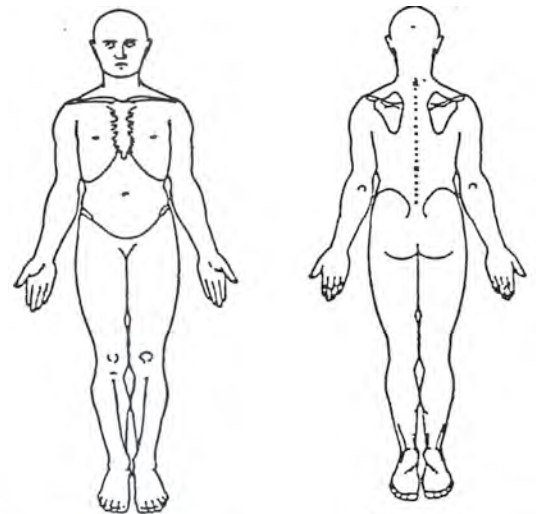
rarely (20-40%)

often (40-60%)

most of the time (60-80%)

always (80-100%)

8. Please indicate on the drawing where the pain/symptoms occurs:



Past History of Symptoms

1. Have you ever had these kinds of symptoms before? yes no

If yes, when? _____

2. How often have they recurred? _____

3. Has the frequency or severity of these symptoms increase since the last time?

Frequency: yes no Severity: yes no