DAILY EXAM

TODAY'S DATE: _____

Print Name: _____ Signature: _____

Home#_____ Cell#_____ Work#_____

BODY PART: _____ Age: _____ Ht: _____ Wt. _____ B/P: _____ Pul: _____

Reason for today's visit: _____

Were you involved in a work-related injury? Yes ( ) No ( )
Were you involved in a motor vehicle accident? Yes ( ) No ( )

How did the pain start? _____ Sudden _____ Slowly

How did you hurt yourself? _____ Injury _____ No Injury (mechanism)

PLEASE DESCRI BE HOW & WHEN INJURY HAPPENED: _____

Where is the pain: _____FRONT _____BACK _____SIDE (LOCATION)
QUALITY: _____ ACHY _____ MILD _____SEVERE (SEVERITY)

Today's Pain Level on a scale 0-10. 0 being the least and 10 being the worst
Please Circle: (NONE) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

How long have you had the pain? _____DAYS _____WEEKS _____MONTHS
How would you describe the pain _____ On & Off _____ Constant (Timing)

Pain improved by: _____Rest _____Ice _____Heat

Progression of pain since onset _____Worsened _____Unchanged _____Improved

Associated Symptoms _____ Night Pain_____ No night pain

Pain aggravated by _____ Activity _____ Pain at Rest

Do you have any of the following (circle)
Swelling Black & Blues Stomach Upset Diarrhea Fever Chills

Tingling Numbness Coldness Burning

What makes the pain feel better? _____

What makes the pain feel worse? _____

PRESENT COMPLAINTS:

	Yes	No		Yes	No		Yes	No
Chills	( )	( )	Double Vision	( )	( )	Nausea/Vomiting/Diarrhea	( )	( )
Fever	( )	( )	Headaches	( )	( )	Painful/Frequent Urination	( )	( )
Night Sweats	( )	( )	Chest Pain	( )	( )	Nervous/Anxious/Depression	( )	( )
Dizziness	( )	( )	Palpitations	( )	( )	Do you bleed easily?	( )	( )
Nose Bleeds	( )	( )	Fainting	( )	( )	Heat/Cold Intolerance?	( )	( )
Neck Swelling	( )	( )	Anorexia	( )	( )	Loss of Appetite	( )	( )
Hearing Problems	( )	( )	Fever	( )	( )	Night Sweats	( )	( )