



14050 N. 83rd Ave Suite 230
Peoria, AZ 85381
Tel: 623-776-7577
Fax: 623-776-7597
www.exclusivelyspine.com

Welcome! We appreciate your help in providing this information we need to complete your medical record.

Name: _____
Last First MI
Home Street Address _____
City State Zip
Phone: _____
Home Work
Cell E-mail
Schedule Reminder: _____ Text _____ Email
Date of Birth: _____ **Age:** _____
Social Security #: _____
Required
Driver's License #: _____

Employer Name: _____
Occupation: _____
 Full time Part time Unemployed Medical Leave
Physician's Name: _____
Phone number: _____ **City:** _____
Date of next scheduled appointment: _____
In case of emergency, please notify:
Name: _____ **Ph:** _____
Have you ever seen one of our therapists before? Yes No
How did you hear about us? _____
Please be specific

(Please provide insurance card and driver's license to be copied.)

Primary Insurance: _____ **Secondary Insurance:** _____
Insured's Social Security#: _____ **Insured's Date of Birth:** _____
Does your employer consider this a work injury? Yes No
Is this injury part of an open car accident case or other personal injury lawsuit? Yes No

I have read and fully understand Exclusively Spine Physical Therapy, LLC's Notice of Privacy Practices. I understand that Exclusively Spine Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Exclusively Spine Physical Therapy, LLC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Exclusively Spine Physical Therapy, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Please provide your e-mail address if you would like to receive our one page monthly newsletter about neck and back related health or notification of future announcements or specials. Note: Exclusively Spine Physical Therapy will not sell or distribute this address to any other vendors or companies.

Email address: _____

I attest that the above information is true and correct.

Printed Name: _____

Signature: _____

Date: _____



14050 W. 83rd Ave, Suite 230
Peoria, AZ 85381
Tel: 623-776-7577
Fax: 623-776-7597
www.exclusivelyspine.com

Notice of Privacy Practices (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change our Notice of Privacy Practices at any time and those changes will apply to any protected health information that we maintain at that time. We will provide you with a revised Notice of Privacy Practice upon request or upon your return for future treatment.

In this notice, "we", "our" or "us" means this FACILITY and our workforce of employees, contractors and volunteers. "You" and "your" refers to each of our patients who are entitled to a copy of this notice. We are required by federal and state law to protect the privacy of your health information. Protected Health Information (PHI) refers to health information that may specifically identify you.

Ways we may use or disclose your Protected Health Information

We use or disclose your PHI for certain activities or health care operations. We will also disclose your PHI as required or permitted by the law.

Treatment: We use and disclose your PHI in the course of your treatment. For example, once we have completed your evaluations or re-evaluations we will send a copy of summary of our report to your referring physician.

Payment: We may disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your PHI including treatments received, diagnosis, and social security number.

Health Care Operations: We may use your PHI to support business activities of this practice. For example; employee review activities, quality assessment, compliance monitoring, training for therapy students and resolution of a complaint.

Special Services: We may also use or disclose your PHI for appointment reminders, follow up calls, advise of new services or supplies offered. We verbally may share some of your PHI with a family member or friend if they are involved in your care. We may use your PHI in an emergency if you are unable to express yourself.

Other required uses of PHI:

1. When required by law.
2. For public health activities. For example reporting a communicable disease or reporting an adverse reaction to the FDA.
3. To report neglect, abuse or domestic violence.



14050 W. 83rd Ave, Suite 230
Peoria, AZ 85381
Tel: 623-776-7577
Fax: 623-776-7597
www.exclusivelyspine.com

4. To the government regulators for purposes such as conducting audits and investigations.
5. To the appropriate military command authorities, If you are a member of the military.
6. To worker's compensation agencies for workers' compensation benefit determination.

Your privacy rights

1. You have the right to request in writing that we do not use or disclose your PHI in a particular way. We are not required to abide by all requests.
2. You have the right to confidential communication if requested in writing. You may request that we use a specific address or phone number or all communication as long as it does not interfere with your method of payment.
3. You have the right to inspect and copy your PHI when requested in writing. We must respond to your request within thirty days. We may charge a reasonable fee for copying and labor time related to copying and we may require an appointment for record inspection.
4. You have the right to make amendments to your PHI if requested in writing. We are not obligated to make all requested amendments. However, if we accept the amendment we must notify you and make efforts to notify others who may have the original record.
5. You have the right to revoke your authorization to disclose your PHI at any time in writing.
6. You have the right to an accounting of certain disclosures that we have made by us regarding your PHI. The request must be in writing.
7. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer, Exclusively Spine Physical Therapy, LLC, 14050 N. 83rd Ave, Ste. 230, Peoria, AZ, 85381.
8. You have the right to complain if you feel your privacy rights have been violated. All complaints should be made in writing to the Privacy Officer, Exclusively Spine Physical Therapy, LLC, 14050 N. 83rd Ave, Ste. 230, Peoria, AZ, 85381. You may also submit a written complaint to the U.S. Department of Health and Human Services.

If you have any questions about this notice please contact the Privacy Officer listed below:

Melissa Hourihan, P.T., D.P.T.
Exclusively Spine Physical Therapy, LLC
14050 W. 83rd Ave, Suite 130
Peoria, AZ 85381

Important Company Policies for a Successful Relationship

We appreciate the confidence you have shown in choosing us as your healthcare provider. We strive to provide the highest quality of care to all of our patients. We will make every effort to schedule appointments that are convenient for you, but we ask that you please follow the guidelines below.

Please initial each policy to indicate that you have read and understand it. Thank you.

_____ **Late Policy “10 minutes”**

Being late will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. Showing up late to an appointment can undeservedly compromise the care of another patient.

_____ **24-Hour Advance Notice Fee**

If you wish to change or cancel an appointment we require a minimum *24-hour advance notice*. Anything less will result in a *\$20 fee* charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a mere *\$20 fee*. We do NOT make money with this charge: it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

_____ **Copay, co-insurance, and deductible payments are due upon arrival**

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an “Extension Request” form. This is a “promise-to-pay” and carries a *\$2.50 fee* that allows you to keep your appointment.

_____ **No-Shows are bad**

If you fail to show for an appointment without notice all future appointments will be removed and a *\$20 fee* will be added to your account. You may reschedule appointments again on a “first come first serve basis.”

_____ **Cell phones must be shut OFF or silent.**

Cell phones/smart phones are a distraction and can be a danger and/or decrease the quality of your care/treatment program. We realize emergencies may arise and therefore allow you to carry your cell phone during your session. However, please be courteous and set to silent mode or turn off. Thank you.

_____ **Children requiring supervision are NOT allowed to attend sessions with you.**

Unless your child does not require supervision, please do not bring them to your appointment. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Please sign your name below indicating that you understand and have read this policy.

Print name

Patient signature

Date

Patient Name: _____ Date: _____

CURRENT SYMPTOMS: *Please describe the symptoms you are seeking treatment for:*

Please use the key below to mark where your symptoms are located and what kind of symptoms you are having.

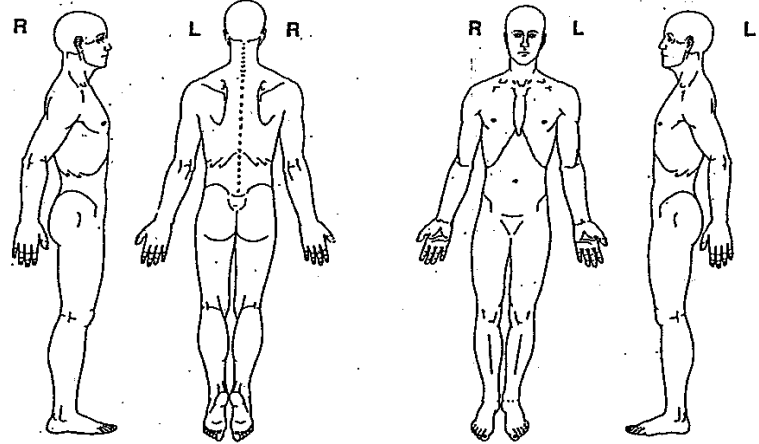
KEY:

Numbness -----

Pins & Needles oooo

Burning Pain xxxxx

Stabbing Pain /////



PAIN LEVELS/SYMPTOM HISTORY

- Please **circle** the number that describes your pain at **worst**. ○
- Please put a **box** around the number that describes your pain at **best**. □
- Please **underline** your **current pain level**. _____

Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst
Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst
Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst
Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst

Are you currently seeing a physician for these symptoms: Yes No

Physician Name: _____ Next scheduled appointment: _____

How long have you had these symptoms? _____

Was the onset of your symptoms gradual or sudden? Gradual Sudden

Have you had similar symptoms in the past? Yes No **More than one episode?** Yes No

Since onset are your symptoms getting: Better Worse Not changing

Please check all that apply about your current symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Work-related injury | <input type="checkbox"/> Recurrence of previous injury | <input type="checkbox"/> Injury related to falling |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Injury related to lifting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cause unknown | <input type="checkbox"/> Athletic/recreational injury | |

As the day progresses, do your symptoms: Increase Decrease Stay the same

What position do you sleep? Back Stomach Right side Left side Chair/Recliner Other: _____

Does the pain wake you at night? Yes No **If yes, is it present:** While lying still With position change

Patient Name: _____ Date: _____

Do you have pain/stiffness upon getting out of bed in the morning? Yes No

What **aggravates** your symptoms? (check all that apply)

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lying down | <input type="checkbox"/> Looking up overhead | <input type="checkbox"/> Reaching overhead |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Going from sit to stand | <input type="checkbox"/> Talking, chewing | <input type="checkbox"/> Reaching behind back |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Up/down stairs | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Reaching in front of body |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Stress | <input type="checkbox"/> Coughing/sneezing | <input type="checkbox"/> Reaching across body |
| <input type="checkbox"/> Sleeping | | <input type="checkbox"/> Taking a deep breath | |
| <input type="checkbox"/> Bending | | | |
- Recreation/sports including _____
- Housework including _____
- Yard Work including _____
- Other _____

What **relieves** your symptoms? (check all that apply)

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Massage | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Topical Creams | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Stretching | _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise | _____ |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Wearing a splint/orthosis | _____ |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Medication | _____ |

PREVIOUS TREATMENTS: Describe any previous treatments you have had for these symptoms:

Treatment: _____ Date: _____ Response to Treatment: _____

PREVIOUS TESTING: Have you had any imaging/testing performed for this condition?

	Yes	No	Approximately when and where were these images taken?
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dexascan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST MEDICAL HISTORY	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Spondylolisthesis	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____ Date: _____

	Yes	No
Kidney or Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Current Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>
Numbness genital/anal area	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes how much?</i> _____	<i>How often?</i> _____	
Smoke	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes how many packs per day?</i> _____		

	Yes	No
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairments	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight change	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes what, how often?</i> _____		
Current Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes how many months?</i> _____		

If yes to any of the listed conditions please briefly explain the condition and date of diagnosis:

Is there any other information regarding your past medical history not listed we should know about? Yes No

Please list any medications prescription and non prescription, vitamins, home remedies, birth control pills, herbs you are taking. Please list dosage and frequency:

<i>Medication:</i>	<i>Dosage (e.g. mg/pill):</i>	<i>Frequency:</i>	<i>What are you taking medication for:</i>

Are you allergic to any medications? Yes No *If yes, please list:* _____

<i>Please list all surgeries you have had:</i>	<i>Surgery:</i>	<i>Date:</i>

FAMILY MEDICAL HISTORY

Has anyone in your immediate family ever had any of the following:

	Yes	No	Relation		Yes	No	Relation
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer/Type	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Death before 50	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any other family history that may be important to your care: _____

HOME ENVIRONMENT

Married Single Living Alone Children Ages: _____

Is help available from spouse/children/roommate with household activities and yard work activities ? Yes No

Does your home have stairs that you are required to climb? _____

Other relevant information about home environment: _____

Patient Name: _____ Date: _____

WORK ENVIRONMENT

- Employed Student Retired Unemployed Homemaker
- Full time Part Time Limited Hours _____ Restricted Duty _____

- Employed but presently not working due to my condition
- Previously employed and receiving disability benefits for my condition

Are you currently seeking disability benefits for this condition? Yes No Short Term Long Term

What is/was your occupation? : _____

What are your physical activities at work? (check all that apply)

- Sitting Standing Phone Use Computer Use Heavy Lifting Repetitive lifting
- Heavy equipment operation Driving Other: _____

PREVIOUS FUNCTIONAL ACTIVITY LEVEL

Prior to this injury....

- How would you rate your overall health? Excellent Good Average Fair Poor
- Were you able to perform all self care activities? Yes No
- Were you able to perform all housework/child care /yard work activities? Yes No
- Were you able to perform all work duties? Yes No
- Did you exercise outside of your normal everyday activities? Yes No
- If yes, how often and what type: _____
- What did your recreational/sport activities consist of: _____

CURRENT FUNCTIONAL ACTIVITY LEVEL

Since the current injury....

If you answer no please elaborate on line below

- Are you able to perform all self care activities? Yes No
- _____
- Are you able to perform all housework/child care /yard work activities? Yes No
- _____
- Are you able to perform all work duties? Yes No
- _____
- Are you able to tolerate your previous exercise activities ? Yes No
- _____
- Are you able to tolerate your previous recreational/sport activities? Yes No
- _____
- Are there any other activities that you are unable to do? Yes No
- _____
- _____

What are your goals for your treatment? _____

Other information you believe is relevant to your treatment: _____



Please read:

This questionnaire has been designed to give the doctor/clinician information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

NAME: _____ DATE: _____

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5 – Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty concentrating when I want to.
- I cannot concentrate at all.

Section 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-5 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

Section 10 – Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck
- I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

Shoulder Pain and Disability Index (SPADI)

Name: _____ Date: _____

Please place circle the number that best represents your experience attributable to your shoulder problem.

Pain Scale

How severe is your pain?

Circle the number that best describes your pain where 0 is no pain and 10 is the worst pain imaginable.

- | | | | | | | | | | | | |
|--|---|---|---|---|---|---|---|---|---|---|----|
| 1. At its worst? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. When lying on the involved side? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. Reaching for something on a high shelf? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. Touching the back of your neck? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. Pushing with the involved arm? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Disability Scale

How much difficulty do you have?

Circle the number that best describes your experience where 0 is no difficulty and 10 is so difficult it requires help.

- | | | | | | | | | | | | |
|--|---|---|---|---|---|---|---|---|---|---|----|
| 1. Washing your hair? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. Washing your back? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. Putting on an undershirt or jumper? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. Putting on a shirt that buttons down the front? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. Putting on your pants? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. Placing an object on a high shelf? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. Carrying a heavy object of 10 pounds? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. Removing something from your back pocket? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |



Symptom Intensity Rating

Patient Name: _____ Date: _____

Please Read:

For each category below, please indicate the severity of the symptoms using the 1-10 point scale where 0 = No Symptoms and 10 = Extreme Symptoms

	No Symptoms					Extreme Symptoms					
Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Shoulder Pain	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Dizziness	0	1	2	3	4	5	6	7	8	9	10
Nausea	0	1	2	3	4	5	6	7	8	9	10
Stiff Neck	0	1	2	3	4	5	6	7	8	9	10
Shoulder Blade Pain	0	1	2	3	4	5	6	7	8	9	10
Arm Pain	0	1	2	3	4	5	6	7	8	9	10
Pins & Needles	0	1	2	3	4	5	6	7	8	9	10
Numbness	0	1	2	3	4	5	6	7	8	9	10
Neck Weakness	0	1	2	3	4	5	6	7	8	9	10
Arm Weakness	0	1	2	3	4	5	6	7	8	9	10