

# PATIENT EXAM FORM

Incident: PI WC Group Cash MC

Insurance: \_\_\_\_\_

NP React Re-exam New Injury

Today's Date (MM/DD/YYYY) \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name (Initial) \_\_\_\_\_

1. What symptoms prompted you to seek care today? \_\_\_\_\_

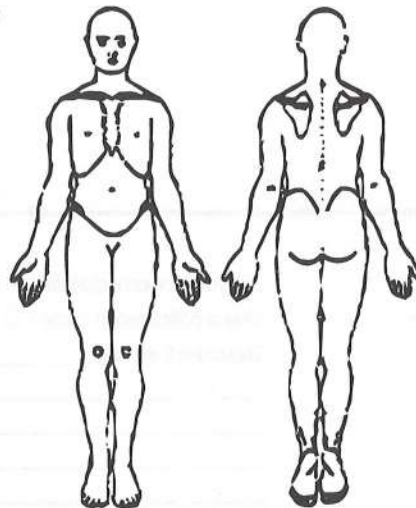
2. When did these symptoms start? How did they start? \_\_\_\_\_

## 3. Quality of Symptoms

Please mark the area(s) of complaint(s)

(What does it feel like?)

- ☐ Numbness
- ☐ Tingling
- ☐ Tightness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Heavy
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing



☐ Other \_\_\_\_\_

☐ Chiropractic: Where \_\_\_\_\_

## 4. Duration & Timing (How often do you feel it?)

- ☐ Constant
- ☐ Comes and goes

## 5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

## Pain Scale:

0 1 2 3 4 5 6 7 8 9 10  
None Mild Moderate Severe Worst

## Sleeping:

0 1 2 3 4  
Perfect Mildly Disturbed Moderately Disturbed Greatly Disturbed Totally Disturbed

## Self-Care:

0 1 2 3 4  
No Pain Mild Pain Moderate Moderate Severe  
No Restrictions Slow Moving Some Ast. 100% ast.

## Travel:

0 1 2 3 4  
No Pain Mild Pain Moderate Moderate Severe  
Long Trips Long Trips Long Trips Short Trips Short Trips

## Work:

0 1 2 3 4  
Usual Duties Usual duties Can do 50% Can do 25% Can't work  
+ extra work no extra of usual of usual

## Recreation:

0 1 2 3 4  
Can do all Can do most Can do some Can do few None  
activities activities activities activities

## Frequency: (% of day)

0 1 2 3 4  
No Pain 25% 50% 75% 100%

## Lifting (Weight):

0 1 2 3 4  
No pain Increased Increased Increased Increased  
Heavy Heavy Moderate Light Any

## Walking Distance:

0 1 2 3 4  
unlimited 1 mile 1/2 mile 1/4 mile any

## Standing (Hours):

0 1 2 3 4  
No pain Increased Increased Increased Any Standing  
Several Several 1 hour 1/2 hour

## PEDIATRIC PATIENTS ONLY

Birth History ☐ Vaginal Delivery ☐ C-Section

Circle One

- Forceps or Vacuum Extraction use? Y or N
- Colic? Y or N
- Reflux Y or N
- Frequent Colds/Ear Infections Y or N
- Eczema or other skin conditions? Y or N
- Lip or tongue tie revision? Y or N

Score: \_\_\_\_\_ / 40