# **PATIENT UPDATE PLEASE PRINT CLEARLY**

Name: Date: / /

Date of Birth: / / Age: 🞏Male 🞏Female

Height: Feet Inches Weight: Pounds

PLEASE LIST ALL OF YOUR CURRENT COMPLAINTS IN ORDER OF PRIORITY

Area Constant/intermittent 0 to 10 Sharp/dull/burning Radiating to

1.

2.

3.

4.

5.

Use back of sheet if needed

1. SINCE INITIAL OFFICE VISIT, HAVE YOU NOTICED ANY CHANGES OF YOUR SYMPTOMS/ INJURIES SINCE YOU HAVE BEEN UNDER CARE: 🞏Better 🞏Worse 🞏No change

If WORSE, explain:

Use back of sheet if needed

2. HAVE YOU HAD/BEEN IN AN ACCIDENT/INJURY OR OTHER ACTIVITY THAT MAY HAVE CAUSED OR EXACERBATED YOUR PRESENT SYMPTOMS/INJURIES SINCE YOUR LAST OFFICE VISIT 🞏Yes 🞏No

If YES, explain:

Use back of sheet if needed

3. HAVE YOUR RETURNED TO YOUR NORMAL WORK/DAILY ACTIVITIES SINCE YOUR LAST OFFICE VISIT: 🞏Yes 🞏No

If NO, explain:

Use back of sheet if needed

4. HAVE YOUR SEEN ANOTHER PHYSICIAN FOR YOUR SYMPTOMS/INJURIES SINCE YOUR LAST OFFICE VISIT: 🞏Yes 🞏No

If YES: Physician’s Name:

Phone Number: ( )

Date Seen: / /

PERFORMING ADL/ACTIVITIES OF DAILY LIVING

Carrying Groceries …………………….... 🞏 No difficulty 🞏 Difficulty performing

Sit to Stand ………………………………. 🞏 No difficulty 🞏 Difficulty performing

Climbing Stairs …………………………... 🞏 No difficulty 🞏 Difficulty performing

Pet Care …………………………………... 🞏 No difficulty 🞏 Difficulty performing

Driving ……………………………………. 🞏 No difficulty 🞏 Difficulty performing

Working on Computer …………………... 🞏 No difficulty 🞏 Difficulty performing

Household Chores ………………………... 🞏 No difficulty 🞏 Difficulty performing

Sweeping/Vacuuming ……………………. 🞏 No difficulty 🞏 Difficulty performing

Standing Washing Dishes ……………...… 🞏 No difficulty 🞏 Difficulty performing

Doing Laundry …………………………… 🞏 No difficulty 🞏 Difficulty performing

Taking Out the Garbage ………………… 🞏 No difficulty 🞏 Difficulty performing

Lifting Child to Care for or Play With … 🞏 No difficulty 🞏 Difficulty performing

Reading/Concentration …………………. 🞏 No difficulty 🞏 Difficulty performing

Bathing Self ………………………………. 🞏 No difficulty 🞏 Difficulty performing

Getting Dressing …………………………. 🞏 No difficulty 🞏 Difficulty performing

Shaving …………………………………… 🞏 No difficulty 🞏 Difficulty performing

Personal relations with significant other. 🞏 No difficulty 🞏 Difficulty performing

Sleeping …………………………………… 🞏 No difficulty 🞏 Difficulty performing

Prolonged Sitting ………………………… 🞏 No difficulty 🞏 Difficulty performing

Prolonged Standing ……………………… 🞏 No difficulty 🞏 Difficulty performing

General Yard Work ……………………... 🞏 No difficulty 🞏 Difficulty performing

Extended Walking ………………………. 🞏 No difficulty 🞏 Difficulty performing

*PLEASE READ INSTRUCTIONS*

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question by marking an “X” along the line that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

*Work normally Unable to work at all  
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

*Take care of myself completely Need help with all my personal care  
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

3. Does your pain interfere with your traveling?  
*Travel anywhere I like Only travel to see doctors*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

4. Does your pain affect your ability to sit or stand?  
*No problems Cannot sit or stand at all*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
*No problems Cannot do at all*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
*No problems Cannot do at all*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

7. Does your pain affect your ability to walk or run?  
*No problems Cannot walk/run at all*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

8. Has your income declined since your pain began?  
*No decline Lost all income*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

9. Do you have to take pain medication every day to control your pain?

*No medication needed Take pain medication throughout the day  
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

10. Does your pain force you to see doctors more often than before your pain began?  
*Never see doctors See doctors weekly*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
*No problems Never see them*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

12. Does your pain interfere with recreational activities and hobbies that are important to you?  
*No interference Total interference*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

*Never need help Need help all the time  
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

14. Do you now feel more depressed, tense, or anxious than before your pain began?

*No depression/tension Severe depression/tension  
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?  
*No problems Severe problems*

*0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10*

# **Signature: Date:**