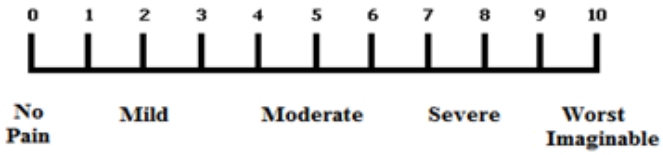
Patient Name:_____ **Date:**_____

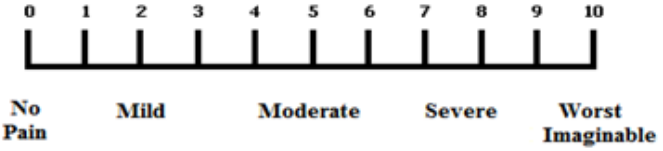
Instructions: Please *circle* the number that best represents the level of pain that you are experiencing *right now.*

PAIN ASSESSMENT

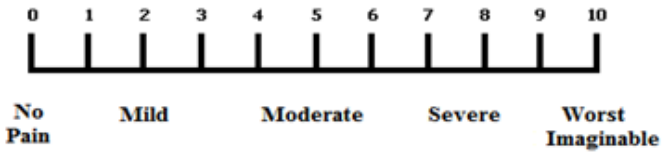
NECK PAIN



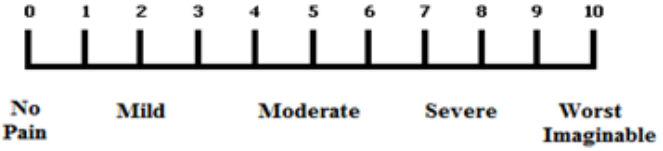
BACK PAIN



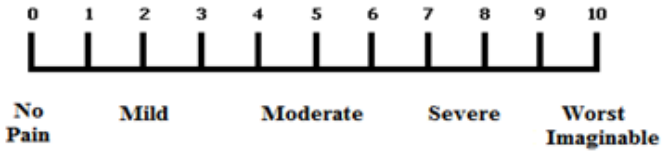
LEFT ARM/SHOULDER PAIN



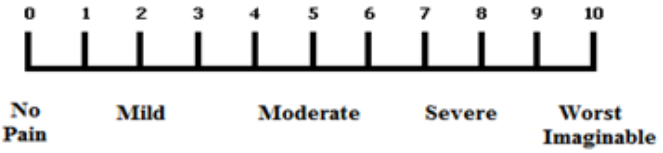
LEFT LEG PAIN



RIGHT ARM/SHOULDER PAIN



RIGHT LEG PAIN



Have you taken any pain medication or muscle relaxers today? □ NO □ YES

Patient Signature:_____ **Date:**_____

Patient Name:_____ **Date:**_____

FUNCTIONAL ABILITIES SURVEY

Instructions: Please select one answer for every question, thinking about your experience **over the past 3 days**. We realize that you may consider that two of the statements in any section may apply to you, but just mark one box that most closely describes your abilities.

Personal Care (Washing, Dressing)

☐ I can take care of myself normally without pain

☐ I am mildly limited with taking care of myself due to pain

☐ I am moderately limited with taking care of myself due to pain

☐ I am severely limited with taking care of myself due to pain

Walking

☐ Symptoms have no effect on my ability to walk

☐ Symptoms mildly limit walking ability

☐ Symptoms moderately limit walking ability

☐ Symptoms severely limit walking ability

Driving

☐ I am not limited in my ability to drive

☐ Driving slightly increases my pain/symptoms

☐ Driving moderately increases my pain/symptoms

☐ Driving severely increases my pain/symptoms

Work/Employment

☐ Symptoms have no effect on my ability to work

☐ Symptoms mildly limit my work activities

☐ Symptoms moderately limit my work activities

☐ Symptoms severely limit my work activities

☐ I am unable to work due to pain/symptoms

Recreational Activities/Hobbies

☐ I can do all activities without increased pain/symptoms

☐ I can do all activities, but it increases my pain/symptoms

☐ Certain activities are restricted due to pain/symptoms

☐ All activities severely restricted due to pain/symptoms

Travel

☐ I can travel without increased pain/symptoms

☐ I can travel but causes increased pain/symptoms

☐ Pain/Symptoms restrict my ability to travel long trips

☐ Pain/Symptoms restrict my ability to travel anywhere

Sitting

☐ Symptoms have no effect on my ability to sit

☐ Symptoms mildly limit sitting ability

☐ Symptoms moderately limit sitting ability

☐ Symptoms severely limit sitting ability

Standing

☐ Symptoms have no effect on my ability to stand

☐ Symptoms mildly limit standing ability

☐ Symptoms moderately limit standing ability

☐ Symptoms severely limit standing ability

Lifting

☐ Symptoms have no effect on my ability to lift

☐ Symptoms mildly limit lifting ability

☐ Symptoms moderately limit lifting ability

☐ Symptoms severely limit lifting ability

Sleeping

☐ Symptoms have no effect on my ability to sleep

☐ Symptoms mildly limit my ability to sleep

☐ Symptoms moderately limit my ability to sleep

☐ Symptoms severely limit my ability to sleep

Patient Signature:_____ **Date:**_____