THROM HEALTH AND WELLNESS

Name: _____ Evaluation #: _____ Date: _____

Describe Complaint:_____
_____
_____

How did it begin? _____
_____
_____

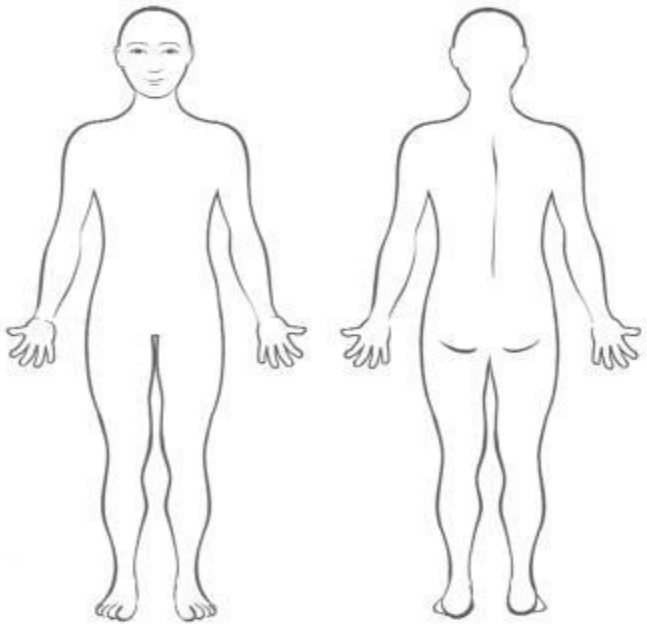
When did it begin?_____
_____

What makes it feel better? _____
_____
_____

What makes it feel worse? _____
_____

Does the pain shoot into your arms or legs? _____
Describe:_____
_____

How often do you experience symptoms?_____
_____
_____



Draw on the Body Front and Back Following This Legend

XXX – Aching Pain →→→ – Sharp/Shooting Pain
000 – Burning Pain **:::::** – Numbness/Tingling

Circle One Number in Each Row of the Pain Scale Below

AT BEST: ☺ 0---1---2---3---4---5---6---7---8---9---10 ☹
AT WORST: ☺ 0---1---2---3---4---5---6---7---8---9---10 ☹
AVERAGE: ☺ 0---1---2---3---4---5---6---7---8---9---10 ☹
RIGHT NOW: ☺ 0---1---2---3---4---5---6---7---8---9---10 ☹

Effect on Activities of Daily Living (ADLs)

0 – No effect **1** – Able to perform with mild discomfort **2** – Able to perform with moderate discomfort
3 - Able to perform with severe discomfort **4** – Limited ability to perform **5** – Unable to perform

_____Lying On Back _____Lying On Side _____Lying On Stomach _____Turning Over In Bed
_____Prolonged Sitting _____Prolonged Standing _____Seated-to-Standing _____Self-Care (hygiene)
_____Walking _____Kneeling _____Bending _____Twisting _____Pushing _____Pulling
_____Reaching _____Gripping _____Coughing _____Sneezing _____Sleeping _____Concentrating
_____Urinating/Defecating _____Sexual Activity _____Other:_____

Health Quiz

Rate your overall health: _____ Poor _____ Fair _____ Good _____ Excellent
Rate your energy level: _____ Poor _____ Fair _____ Good _____ Excellent
Rate your diet: _____ Poor _____ Fair _____ Good _____ Excellent
Rate your sleep quality: _____ Poor _____ Fair _____ Good _____ Excellent
How many hours of sleep do you get per night? _____
What is your daily intake of each of the following? _____Water _____Fruits/Vegetables
_____Caffeine _____Tobacco _____Alcohol _____Other:_____

Goals of Treatment/Progress Since Last Exam

_____
_____
_____

Doctor Signature: _____