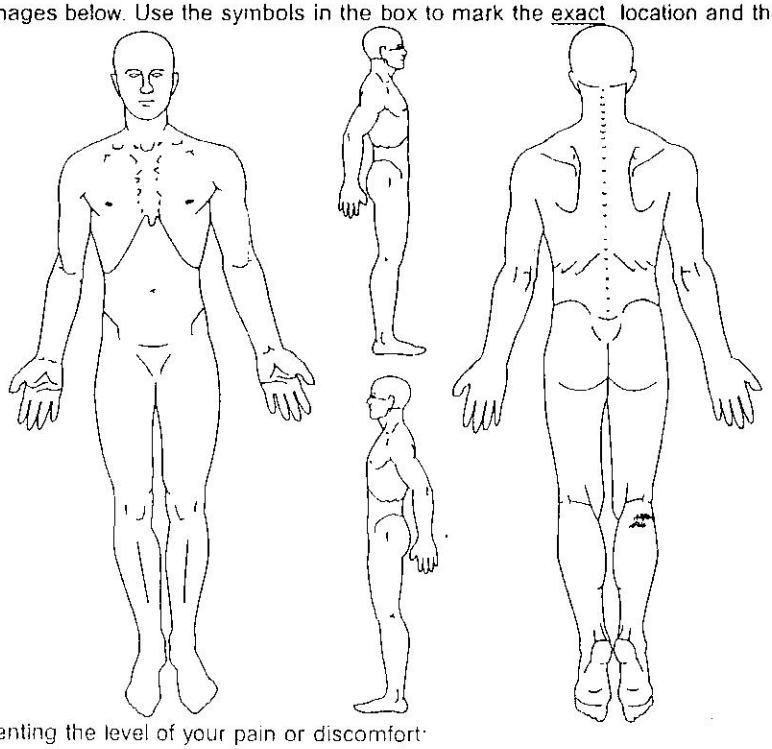
Patient's Name (Print) _____ Date _____

Please draw the location of your pain or discomfort on the images below. Use the symbols in the box to mark the exact location and the type of pain or sensations you are feeling.

>>>	Aching Pain
XXX	Burning Pain
= = =	Numbness
OOOO	Pins & Needles
/////	Stabbing Pain



On the scales below, please draw a vertical line representing the level of your pain or discomfort:

1. Rate the pain you have right **now**:

No Pain ——— Unbearable Pain

2. Rate your **average** pain in the past week:

No Pain ——— Unbearable Pain

3. Rate your pain at its **best** in the past week:

No Pain ——— Unbearable Pain

4. Rate your **worst** pain in the past week:

No Pain ——— Unbearable Pain

Gait _____ Ambulation _____ BP _____ Pulse _____ Weight _____

Major complaint _____

History _____

Related pain-paresthesia _____

Aggravation factors _____

Relief factors _____

Cervical	left	right	Lumbar	left	right	Manual Test	left	right	Other
Rotation			Rotation			Delts			
Lat. flexion			Lat. flex			Biceps			
Flexion			Flexion			Triceps			
Extension			Extension			Wrist Flex			
For. compres.			For. Comp.			Wrist Ext			
Georges			Kemps			Hams			
Spurlings			SLR			Psoas Maj.			
Carotid			Valsalva			Quads			
			Torque Test			Great Toe Ext			
			Hip Ext			Great Toe Flex			
			Hip Int						
			Abdominal B.						

Painful hypertonic muscles _____

Joint fixations _____

Deep tendon reflexes:					Dermatome				
C-5					C-5			L-3	
C-6					C-6			L-4	
C-7					C-7			L-5	
L-4			S-1		C-8			S-1	

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain: 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____