



Universal Chiropractic & Functional Rehabilitation

2354 MARITIME DRIVE, SUITE 100 ELK GROVE, CA 95758 PH.916.683.3900 FX.916.683.3339

VISUAL ANALOG SCALE, PAIN DRAWING & ADL

Name: _____

Date: _____ PI WC GI PP

Section 1 - Pain Intensity:

Please circle the appropriate # that describes your present pain levels, with 0 being no pain and 10 being the worst pain you can imagine. Normal (0-1) Mild (2-4), Moderate (5-7) Severe (8-10)

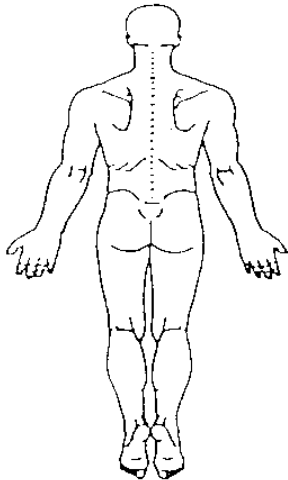
Frequency of Pain:

Circle N if your pain is 0-10%, of time or less
 Circle O if your pain is 25% of time
 Circle I if your pain is 50% of time
 Circle F if your pain is 75% of time
 Circle C if your pain is 100% of time

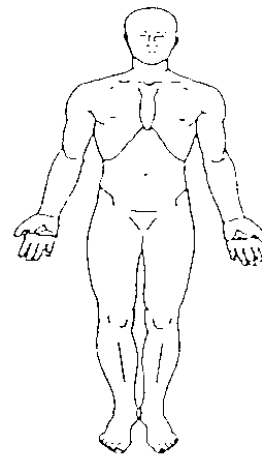
Area of pain	Normal	Mild	Moderate	Severe	Frequency
Neck	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Headaches	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Mid back pain	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Low back pain	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Hip(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Shoulder(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Arm(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Leg(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	N O I F C
Other: Lt Rt	0 1	2 3 4	5 6 7	8 9 10	N O I F C

Section 2 - Pain drawing & Description:

Please indicate the appropriate location of your pain and use the symbol to that best describes the discomfort that you are presently experiencing.



vvvvv = dull & achy
 ++++ = sharp & stabbing
 0000 = pins & needles
 ///// = numbness



Section 3 - Activities of Daily Living or Job Demands that increase your pain levels:

Sitting Standing Stooping Bending Climbing Reaching Lifting (max)____
Driving Housework? _____ Sports/Recreation? _____ Yard Work? _____

Section 4 - Mechanism of Injury:

Please describe what initially caused your problem: _____
 How long have you had this problem? _____ Is the pain getting Better? Worse? Same?
 Pain affects your, Work? / Sleep? / Activities of daily living? / Is pain worse at night?
 Are you currently under medical care for this condition? No Yes Where and what type? _____
 Taking any prescription medications? No Yes What? _____
 Taking non prescription medications? No Yes What? _____ Have you seen another chiropractor?
No Yes Why? _____ List dates and type of any Illness/Surgeries/Accidents:



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PATIENT SPECIFIC FUNCTIONAL SCALE

Patient: _____

Date: _____

List 3 important activities that you are unable to do or have difficulty with as a result of your problem and the location of the pain?

Activity:

Area of pain:

1. _____

(Unable to perform) **circle** 0 1 2 3 4 5 6 7 8 9 10 (performance at pre-injury level)

2. _____

(Unable to perform) **circle** 0 1 2 3 4 5 6 7 8 9 10 (performance at pre-injury level)

3. _____

(Unable to perform) **circle** 0 1 2 3 4 5 6 7 8 9 10 (performance at pre-injury level)