Update Report

Patient Name: _____ DOB: ____/_____/____

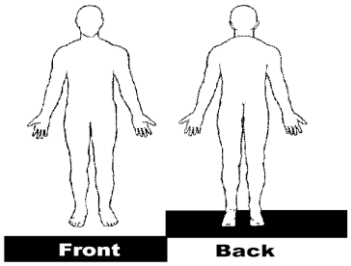
Where and what are your symptoms? _____

Symptoms are; ☐ different than ☐ worse than ☐ similar to ….prior symptoms.

When did they begin? _____

If known, please identify the cause of symptoms: _____
_____

Please mark on the diagram where the symptoms are present:



SYMPTOMS BEGAN: Gradually or Suddenly

THE PAIN IS: Sharp - Stabbing - Burning - Throbbing - Dull - Tingling - Other: _____

HOW DO YOU FEEL TODAY? (place X on line) Best ◄——————————► Worst

WHAT % OF THE DAY ARE THE SYMPTOMS PRESENT? 0-25% - 26-50% - 51-75% - 76-100%

PAIN SCALE: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

THE PROBLEM IS INCREASED BY: Coughing - Straining - Sneezing - Standing - Sitting -
Other Specific Activity (please list)?_____

WHO ELSE HAVE YOU SEEN ABOUT THIS? _____

WHAT HAVE YOU DONE FOR TREATMENT?: Rest - Heat - Stretching - Ice - Physical Therapy -
Medication: (list)_____ Other: _____

What household, social, recreational, or work activities are now difficult or impossible to do now?
_____
_____

Patient Signature: _____*Today's Date:*___/___/____

**********Doctor Notes**********

Confirm onset date: ____/_____/____

Confirm complaint/any additional information: _____

_____

_____

_____

_____

Progression: Same Worse Better _____

Quality: Frequency = occasional / intermittent / frequent / constant _____

Daily / weekly / monthly _____

Pain scale = 0 1 2 3 4 5 6 7 8 9 10

Radiation of pain: _____

Site of pain: _____

Time of symptoms: _____

What makes pain better: _____

_____

_____

What makes pain worse: _____

_____

_____

Recent or past traumas: _____

_____

Additional notes: _____

_____

_____

_____