Change of Condition Report

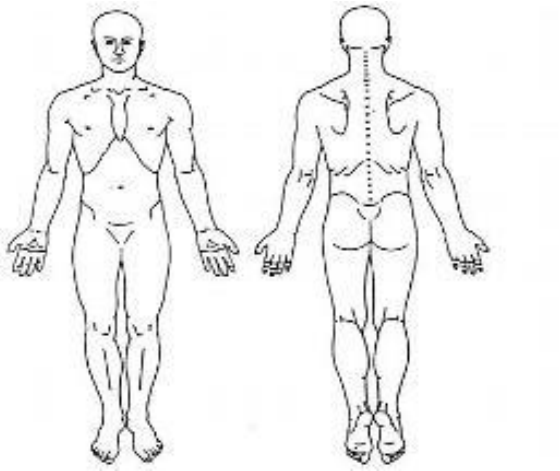
Name:_____ Chart #:_____ Date:_____

1. List any falls, accidents or injuries you have sustained since your last visit:_____
_____
_____

2. When and how did your symptoms begin?:_____
_____
_____

3. On a scale of 1 to 10 (1 being no pain: 10 being the worst pain), what is your current pain level:_____

4. Where is your pain currently located?
(please mark on chart):



5. How would you describe your pain?
- ☐ Shooting
- ☐ Stabbing
- ☐ Sharp
- ☐ Burning
- ☐ Other:_____
- ☐ Numbness
- ☐ Dull
- ☐ Tender
- ☐ Tingling

6. How often do you experience your symptoms?:
- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

7. List any other unusual pains, discomforts, or other symptoms:_____
_____
_____

8. List any movements or positions that aggravate your condition:_____
_____
_____

9. What daily activities are disrupted by your pain? (walking, sleep, dressing, sitting, relationships, work, etc.):
_____
_____

10. What have you done to relieve your symptoms:_____
_____

11. Have you received any other care? When and where?_____
_____