**NAME: DATE:**

*In order to fill out this questionnaire, make sure that you are able to edit the document, you may need to download it into word.*

*To select your answers, click on the wording in RED, this will them bring up a drop down arrow, Click on the dropdown arrow and make your selection.*

*If you have any questions regarding the questionnaire, please do not hesitate to contact our practice.*

**Current Self-Reported Pain**

*In the last week where 0= no pain and 10 = extreme pain how would you rate your pain?*

At its best out of 10:    Best out of 10

At its worst out of 10:     Worst out of 10

**Any Easing factors?**

**Any aggravating factors?**

**Self-reported tolerances**

*Please provide comment on your tolerances for the following*

|  |  |  |  |
| --- | --- | --- | --- |
| Sitting | Minutes (mins) | Lifting | Kgs (kgs) |
| Walking | Minutes (mins) | Carrying | Kgs (kgs) |
| Static Standing | Minutes (mins) | Pushing | Kgs (kgs) |
| Dynamic Standing | Minutes (mins) | Pulling | Kgs (kgs) |

**Self-reported restrictions**

***Please provide comment on any current physical restrictions due to your compensable injury***

**Activities of Daily Living**

*Please provide comment on your ADLs. (No restriction, slight restriction, significant restriction, total restriction, not applicable.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Bed Making | Restrictions | Cooking | Restrictions |
| Child Care | Restrictions | Gardening | Restrictions |
| Cleaning | Restrictions | Transfers | Restrictions |
| Self-Care | Restrictions | Vacuuming | Restrictions |
| Shopping | Restrictions | Ironing | Restrictions |
| Other | Restrictions | Washing | Restrictions |

**Work Status**

|  |  |
| --- | --- |
| Are you currently working | Work Status |
| If Yes, how many hours per day | Hours per day |
| How many days per week | Days per week |

***Goals:***

MEDICATION

Please list any medications that you are currently taking/prescribed.

|  |  |  |
| --- | --- | --- |
|  | Dosage |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Medication Name Dosage Times per day