



# Initial Problem Status Report

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Identify **CURRENT** symptomatic areas in your body by drawing the symbols on the figures below.

Key: ○ Circle areas of **PAIN**  
(Please describe pain as “Sharp”, “Dull ache”, “Burning”, “Tingling”, etc.)

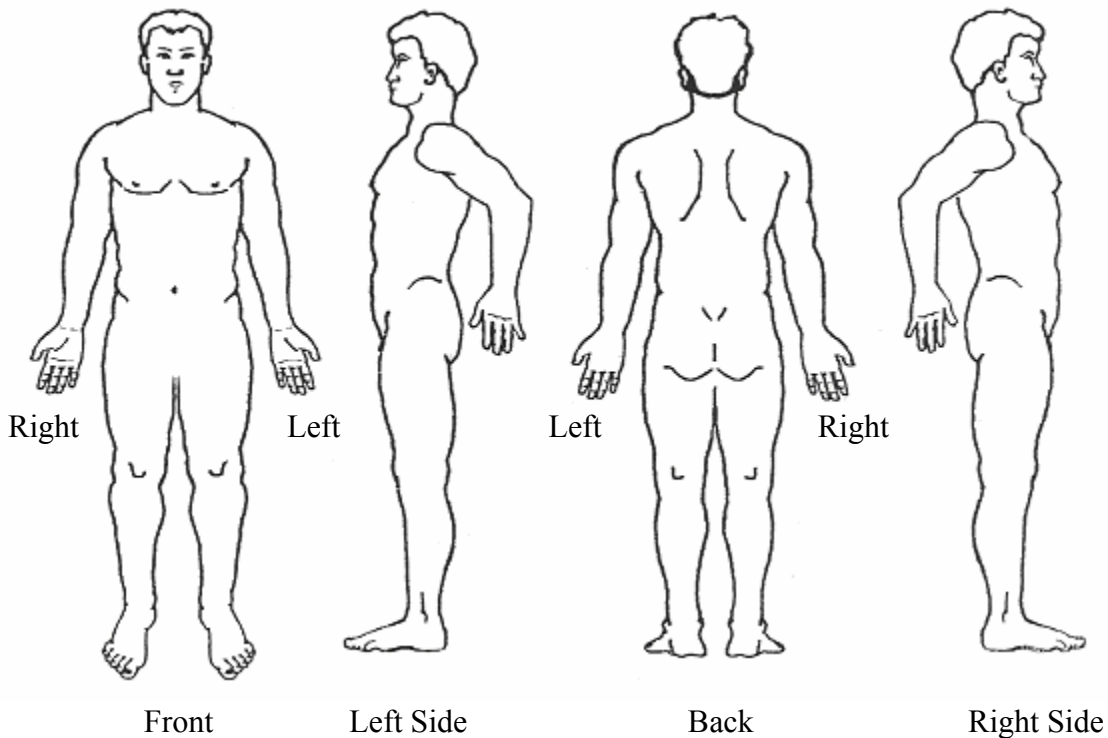
X “X” over areas of **JOINT AND MUSCLE STIFFNESS**

⋈ Draw squiggly lines along the areas of **NUMBNESS OR TINGLING**

+++ Mark **SCARS, BRUISES** or **OPEN WOUNDS**

**( PLEASE NUMBER PRIMARY COMPLAINT  
FROM 1, 2, 3 etc... and describe on the back )**

Example: (#1) this would have a circle around the painful right shoulder



Additional comments:

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Please Complete the Other Side →

**Description of Onset/ Progression of Problem:**

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<b>Mechanism of Injury was:</b> (Check/ brief description)			
<input type="checkbox"/>	Injury – Lifting	<input type="checkbox"/>	Cause Unknown
<input type="checkbox"/>	Recurrence of Previous Injury	<input type="checkbox"/>	Work Related Injury
<input type="checkbox"/>	Injury-Falling	<input type="checkbox"/>	Motor Vehicle
<input type="checkbox"/>	Athletic/Recreational Injury	<input type="checkbox"/>	Other

**Description of Chief Complaint / Primary Symptoms:** e.g.: pain or stiffness, neck, back, etc...

Pain in \_\_\_\_\_  
 Pain Scale 0 1 2 3 4 5 6 7 8 9 10 (with 10 being the worst)

Stiffness in \_\_\_\_\_

Weakness in \_\_\_\_\_

Numbness in \_\_\_\_\_

Symptoms worse with \_\_\_\_\_

Symptoms better with \_\_\_\_\_

Disturbed Sleep  Yes  No

Prior Treatment:  Yes  No – Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Results  Good  Fair  Bad

Prior Episodes for similar problems:  
 None  
 Once within the past year (when) \_\_\_\_\_  
 Multiple times (\_\_) in \_\_\_\_ years  
 Constant since \_\_\_\_\_

**Reason for Visit:**

<input type="checkbox"/>	Increased Pain
<input type="checkbox"/>	Decline Function
<input type="checkbox"/>	Loss of Motion/Strength – Describe: _____
<input type="checkbox"/>	Other _____

**Occupation/ Leisure Activities:**  
 What physical duties are required for you job or activities?  
 \_\_\_\_\_  
 \_\_\_\_\_

Do your symptoms limit your performance? \_\_\_\_\_  
 \_\_\_\_\_