

SYMPTOM INTENSITY AND FREQUENCY FORM

PATIENT: _____ DATE: _____

For **SECTION 1**, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A zero (0) indicates that no symptoms exists. **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level or where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. A **8-10 pain** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks. For **SECTION 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	MINIMAL Discomfort/Ache/Stiff			SLIGHT-TO-MODERATE Hurts/Sore/Bearable Sensation				SEVERE Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional			Intermittent			Frequent		Constant	
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 2b. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how many medications you are taking as well as how long each headache typically lasts.

A. How frequently do you have headaches/migraines currently?

<input type="checkbox"/> No headaches	<input type="checkbox"/> once a week	<input type="checkbox"/> 4 times a week
<input type="checkbox"/> once a month	<input type="checkbox"/> twice a week	<input type="checkbox"/> 5 times a week
<input type="checkbox"/> twice a month	<input type="checkbox"/> 3 times a week	<input type="checkbox"/> Almost daily

B. How many headache medication pills have you taken in the past week? _____ Pills?

C. How many hours does your typical headache/migraine last? _____ Hours?