PERSONAL INFORMATION

DATE COMPLETED :		REFERRED BY :	
NAME & SURNAME (NO NICKNAMES) :		CONTACT NUMBER :	
DATE OF BIRTH :		AGE :	
FEMALE / MALE :		WEIGHT :	
EMAIL :		HEIGHT :	

1. WHERE IS THE PAIN ? (TICK / HIGHLIGHT APPLICABLE BLOCKS) ***R = RIGHT L = LEFT***

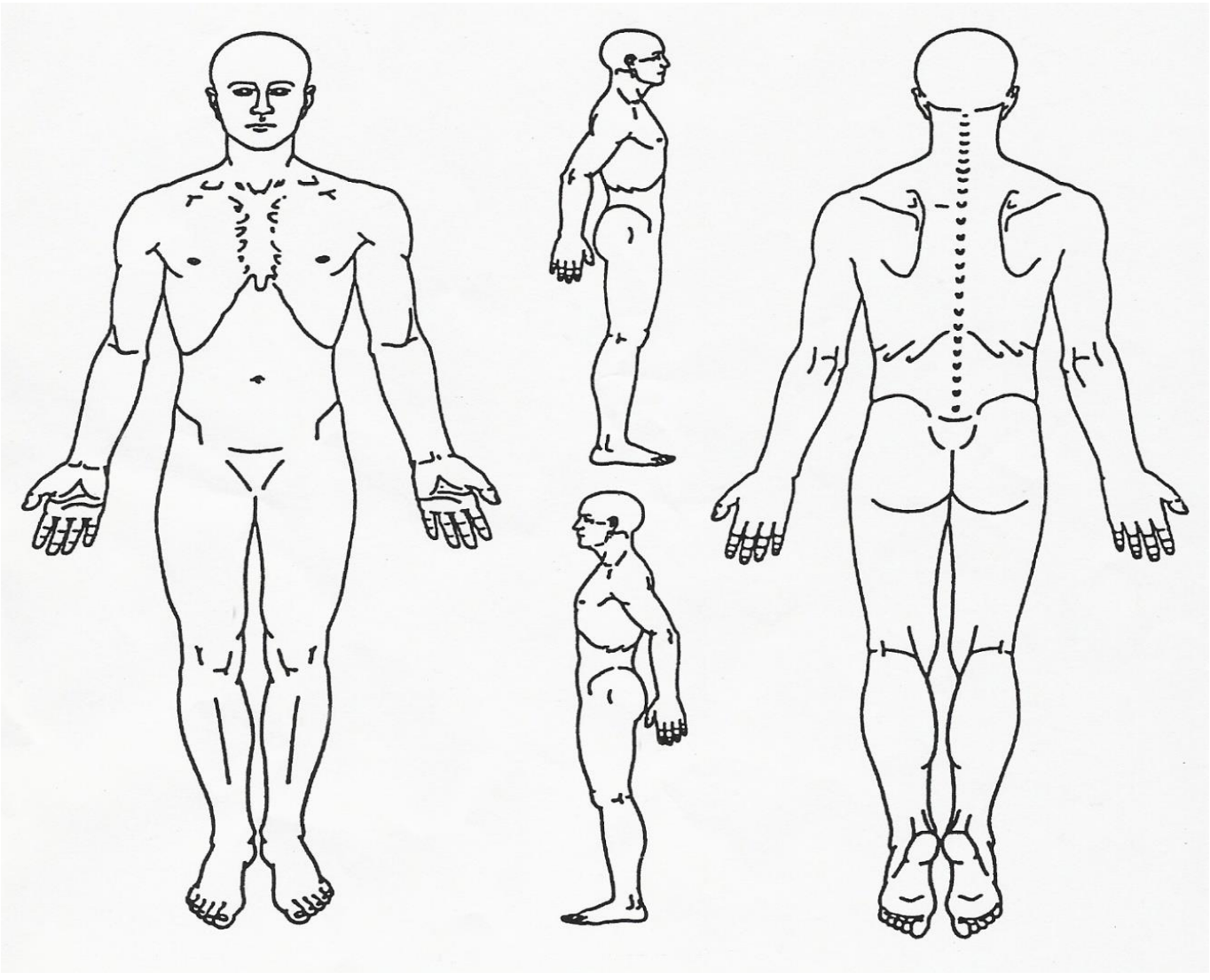
NECK	SHOULDER		ARM		HAND		THUMB		INDEX		MIDDLE		RING		PINKY	
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L

BACK	BUTTOCK		GROIN		LEG		CALF		FEET		BIG TOE		LITTLE TOE	
	R	L	R	L	R	L	R	L	R	L	R	L	R	L

Please tick / highlight the symptoms you are experiencing.

A = Ache		**B = Burning**		**R = Radiating Pain**		**D = Pain**	
N = Numbness		**S = Stabbing**		**P = Pins & Needles**		**O = Other**	

Please indicate on the below diagram the direction of your sympotms.



2. HOW LONG HAVE YOU HAD THIS PAIN?

3. IS IT GETTING BETTER OVER PAST FEW DAYS OR WEEK?

YES		NO	

4. CAN YOU WALK A NORMAL DISTANCE?

YES		NO	

5. IS THE PAIN RELIEVED BY LYING DOWN?

YES		NO	

6. ANY URINARY INCONTINENCE?

YES		NO	

7. ANY WEAKNESS OR CLUMSINESS IN THE LEGS / ARMS/HANDS?

YES		NO	

8. CAN YOU STAND TIP TOE AND ON YOUR HEELS?

YES		NO	

9. ANY LOSS OF WEIGHT?

YES		NO	

10. HOW MANY DAYS IN A WEEK ARE YOU TAKING PAIN KILLERS?

11. PLEASE SELECT THE NUMBER THAT BEST DESCRIBES THE QUESTION BEING ASKED

(0 = NO PAIN - 10 = WORST PAIN POSSIBLE)

11.1 WHAT IS YOUR PAIN RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

11.2 WHAT IS YOUR TYPICAL OR AVERAGE PAIN?

0 1 2 3 4 5 6 7 8 9 10

11.3 WHAT IS YOUR PAIN LEVEL AT ITS BEST (HOW CLOSE TO "0" DOES YOUR PAIN GET AT ITS BEST)?

0 1 2 3 4 5 6 7 8 9 10

11.4 WHAT IS YOUR PAIN LEVEL AT ITS WORST (HOW CLOSE TO "10" DOES YOUR PAIN GET AT ITS WORST)?

0 1 2 3 4 5 6 7 8 9 10

12. ANY RELEVANT MEDICAL PROBLEMS- DIABETES, CARDIAC PROBLEMS, PREVIOUS MALIGNANCIES?

13. HAVE YOU HAD ANY RADIOLOGY INVESTIGATION? IF SO **WHERE** AND **WHAT** HAVE YOU HAD DONE?