Cremorne Physio

New injury information sheet

Name:_____

In which part of your body is your current injury located? _____

Have you seen anyone else in relation to your current injury? ☐ Yes ☐ No

*If yes, who?*_____

What are your expectations from today's session?

a)_____

b) _____

Why is it important to you that you get rid of your injury/problem as soon as possible? _____

_____

CLINCIAL OUTCOMES QUESTIONNAIRES

Please complete the following 2 questionnaires. These will enable us to understand your injury better, the pain you experience and how it affects your daily life.

On the **0 to 10 scale** below put an **X** through the number that best pinpoints **your current level of pain.**

0	1	2	3	4	5	6	7	8	9	10

"No Pain" "Moderate pain" "Severe pain"

Please identify up to **3 important activities** that you are **unable to, or have difficulty performing** as a result of your problem.

(For example; lifting objects, bending over, brushing hair, turning my head, etc)

Scoring scheme:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

able to perform activity at pre-injury level (normally)

Activity	**First Visit**				
1.					
2.					
3.					
Additional					
Additional					

*Note: If you have a **back or neck injury**, please turn over this page and complete the next page.*

Functional Rating Index

For use with **Neck and/or Back Problems** only. In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

1. Pain Intensity

0	1	2	3	4
NoPain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed sleep	Totally Disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain No restrictions	Mild pain no restrictions	Moderate pain, need to go slowly	Moderate pain, need some assistance	Severe pain, need 100% assistance

4. Travel (driving, etc)

0	1	2	3	4
No pain on Long trips	Mild pain on long trips	Moderate pain on long Trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do Usual work Plus unlimited Extra work	Can do usual work, no extra	Can do 50% of Usual work	Can do 25% of usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional pain – 25% of the day	Intermittent pain – 50% of the day	Frequent pain – 75% of the day	Constant pain 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name:_____

Score:_____

Signature:_____

Date:_____