

**FORGEY SPORTSMED & REHAB CLINIC, PLLC**  
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**RATE YOUR FUNCTION:** Place an X on the line below representing your current level of function.

COMPLETE \_\_\_\_\_ NO  
 FUNCTION \_\_\_\_\_ FUNCTION

Job Title: \_\_\_\_\_ Are you currently working: Yes \_\_\_\_\_ No \_\_\_\_\_

Check all appropriate: Full time \_\_\_\_\_ Full duty \_\_\_\_\_ Part time \_\_\_\_\_ Light Duty \_\_\_\_\_

Work Schedule: \_\_\_\_\_

Describe your job duties: \_\_\_\_\_

Maximum Lifting up to \_\_\_\_\_ lbs Occasional Lifting up to \_\_\_\_\_ lbs

If newly employed list employers name, job title, and duties: \_\_\_\_\_

**RATE YOUR PAIN:** Place an X on the line below representing your current level of pain.

PAIN \_\_\_\_\_ WORSE POSSIBLE  
 FREE \_\_\_\_\_ PAIN

*Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

<p>Ache: &gt;&gt;&gt;</p> <p>Numbness: ===</p> <p>Pins/Needles: ooo</p> <p>Burning: xxx</p> <p>Stabbing: ///</p> <p>Throbbing: ~~~</p>		<p><b>Mark the appropriate selection below.</b></p> <p><b>The pain is worse:</b></p> <p>( ) first wake                  ( ) morning                  ( ) mid day                  ( ) afternoon                  ( ) evening                  ( ) bedtime</p> <p><b>The pain is least:</b></p> <p>( ) first wake                  ( ) morning                  ( ) mid day                  ( ) afternoon                  ( ) evening                  ( ) bedtime</p>
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Frequency of pain: ( ) Intermediate 25% ( ) Occasional 25-50% ( ) Frequent 50-75% ( ) Constant 75%

Average time of day in pain: ( ) <1 hr ( ) 1-4 hrs ( ) 4-8 hrs ( ) when not lying down ( ) 24 hrs

What activities make the pain better: \_\_\_\_\_

What activities make the pain worse: \_\_\_\_\_

**RATE YOUR ACTIVITY FUNCTION:** Place an X on the line below representing your current level of function.

COMPLETE FUNCTION \_\_\_\_\_ NO FUNCTION

**Patient Name: (Print)** \_\_\_\_\_

**Patient Name: (Signature)** \_\_\_\_\_ **Date:** \_\_\_\_\_