

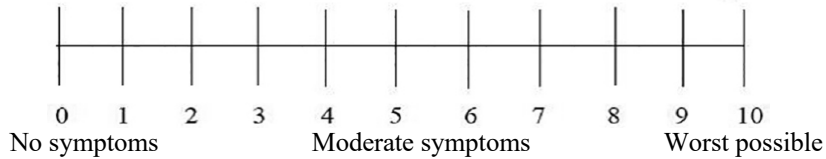
General Pain and Function Scale

Patient Name: _____ Date of Birth: _____

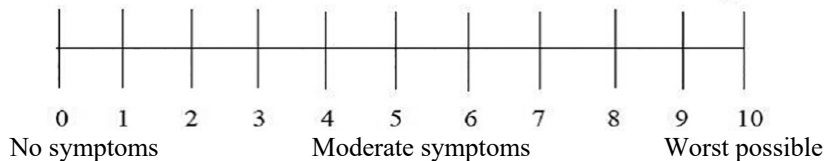
Signature: _____ Today's Date: _____

Please note your symptoms and concerns, and the level or range of dysfunction and/or pain you experience as a result of each. We are interested in tracking your health concerns, so feel free to list more than 3 if needed.

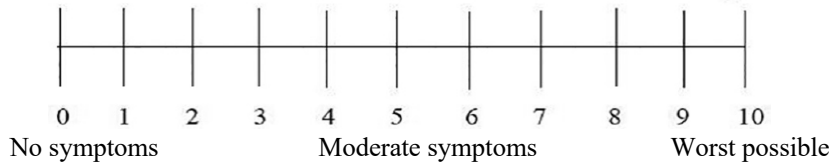
First Symptom:



Second Symptom:



Third Symptom:



Please indicate any new symptoms or events here and note on the diagram below:

When did the new symptoms begin? _____

How did they occur?

Please rate your new symptoms.

