File Review Form
Form CC

File #________

Name: ______________________________ Date: ______________

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Are there any other problems that you would like addressed? ______________________

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Please indicate below your level of improvement:

- ☐ Completely recovered
- ☐ Much improved
- ☐ Slightly improved
- ☐ Neutral
- ☐ Slightly worse
- ☐ Much worse
- ☐ Worse than ever

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Pain Scale: Rate the severity of your pain (as it is right now) by checking one box:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Excruciating Pain

Changes/Limitations in Activities of Daily Living due to your injury:

Sleep:
- ☐ Moving in Bed
- ☐ Getting Settled
- ☐ General Sleeping

Self Care:
- ☐ Dressing
- ☐ Bathing/Showering
- ☐ Hair Care
- ☐ Personal Care/Hygiene

Sports:
- ☐ Exercising
- ☐ Walking
- ☐ __________
- ☐ __________

Hobbies:
- ☐ Reading
- ☐ Watching TV
- ☐ __________
- ☐ __________

Care of Children
- ☐ Lifting child
- ☐ Picking up toys
- ☐ Bathing/Washing child
- ☐ General Care

Care of Home:
- ☐ Vacuum/clean
- ☐ Dishes/Cooking
- ☐ Lawn/Garden
- ☐ Garbage

Limitations: Check all that apply:

I have difficulty...

- ☐ Kneeling
- ☐ Bending
- ☐ Twisting
- ☐ Sitting
- ☐ Standing
- ☐ Climbing Stairs
- ☐ Climbing Ladder
- ☐ Reaching
- ☐ Walking
- ☐ Driving
- ☐ Repetitive Work
- ☐ Writing
- ☐ Lifting Floor to waist
- ☐ Lifting Waist to shoulder
- ☐ Keyboarding/Computer use

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