cohere HEALTH

Patient Pain and Function Assessment

Today's date _____ / _____ / _____

Your personal information

Name (Last, First, MI) _____

Date of birth (MM/DD/YYYY) _____ / _____ / _____

Insurance member ID _____

When did symptoms start? It's okay if you don't know the exact date, an estimate is fine.

Estimated start of symptoms (MM/DD/YYYY) _____ / _____ / _____

Use the 0-10 scale below to answer the following 2 questions

0 No hurt

2 Hurts little bit

4 Hurts little more

6 Hurts even more

8 Hurts whole lot

10 Hurts worst

Write the number that would you describe your pain in the **last week**? _____

Write the number that would you describe your pain in the **last 24 hours**? _____

How is your condition (e.g., your pain level and ability to perform your usual daily activities) changing, since you began receiving care at this facility or provider? Check a number below.

Much worse ☐ 1 — Worse ☐ 2 — Little worse ☐ 3 — No change ☐ 4 — Better ☐ 5 — Much better ☐ 6

☐ N/A this is my first visit

How much do your symptoms interfere with your usual daily activities? Check a number below.

Not at all ☐ 1 — A little bit ☐ 2 — Moderate ☐ 3 — Quite a bit ☐ 4 — Extrememly ☐ 5

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For provider use only

How to use this document

Please have the patient complete the recommended patient assessment tool according to their conditions. DO NOT FAX OR OTHERWISE RETURN THIS FORM TO COHERE. FINAL QUESTIONNAIRE SCORE & PATIENT REPORTED INFO MAY ONLY BE SUBMITTED VIA THE COHERENEXT: PLATFORM CLINICAL ASSESSMENT QUESTIONS UPON CREATING OR UPDATING AN AUTHORIZATION REQUEST.

Patients related issue	Questionnaire to use
Spine - lower back	Oswestry low back pain disability
Spine - neck	Neck Disability Index - Vernon and Mior Cervical Spine
Knee	KOOS (Knee Injury & Osteoarthritis Outcome) Jr.
Hip	HOOS (Hip disability and Osteoarthritis Outcome) Jr.
Shoulder	ASES Shoulder Score
Foot	The Foot & Ankle Disability Index (FADI) Score

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