

POLDCARTS

- P** (**Previous history**) Have you ever experienced this before?
- O** (**Onset**) When did you first notice this? When did it start?
- L** (**Location**) Can you point to where it bothers you the most?
- D** (**Duration**) How long does it last? (is it intermittent, constant....)
- C** (**Characteristic**) Can you describe it? (sharp, dull, stabbing, pins and needles...)
- A** (**Aggravates**) What makes it worse?
- R** (**Relief**) What makes it better?
- T** (**Time**) When do you notice it? (in the morning/all day, just at night...)
- S** (**Scale**) On a scale of 0-5 how would you describe it?