IT IS ESSENTIAL THAT YOU FILL OUT THIS SHEET FOR EACH COMPLAINT YOU WOULD LIKE TREATED

What **one** main health issue brings you here_____

Pain Description (circle)

Aching	burning	cramping	deep
Dull	itching	numbing	numbness
Pins & needles	radiating	shooting	sharp
Painful soreness	painful tension	painful tightness	spasming
Stabbing	stiffness with pain	superficial	throbbing
Tingling	other_____		

For each of the above that you have circled, please place a number next to it indicating how severe
1 mild 2 mild to moderate 3 moderate 4 moderate to severe 5 severe

Condition onset: When did this start?_____

If there is a date of injury, tell us when and how?_____

Overall Pain rating (circle)

No Pain Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Circle one please

With activity without activity with and without activity with work without work

Circle one please

Sporadic intermittent constant occasional persistent constant varies none

If the pain radiates, where does it go?_____

Aggravating factors (circle)

Bending	coughing	driving	exercise
Head rotation	household chores	lying on back	lifting
Looking down	looking up	movement	rapid movements
Reaching	resting	scooping	sitting
Sleeping	sneezing	stairs	standing
Stooping	straining	twisting	typing
Walking	working	Other_____	

Relieving Factors (circle)

Adjustment provided	Topical analgesic	Lying on back with knees up
Exercises/Stretches	Heat	Ibuprofen, aspirin, etc
Ice	Lying down	Leaning against a support
Massage	Medication	Movement
No movement	Resting	Sitting
Standing	Walking	Other_____

If there was an injury, did you have pain here before that injury?(circle) YES NO

Have you had this condition before this event?(circle) YES NO

What other doctors have you seen for this condition?_____