Patient Name: _____ Today's Date:_____

REASON FOR APPOINTMENT:

☐ Injury ☐ Accident ☐ Work related Injury

LITIGATION? ☐ Yes ☐ No

HISTORY OF YOUR PAIN (WHEN DID THE PAIN BEGIN?/WHERE IS THE PAIN?):

WHAT BEST DESCRIBES PAIN? ☐ Constant ☐ Intermittent ☐ With Activity ☐ Dull ☐ Achy ☐ Sharp ☐ Burning

PAIN INTENSITY (0-10): Now___/10 Least Pain___/10 Average Pain___/10 Worst Pain___/10 After Procedure___/10

WHAT MAKES IT WORSE? ☐ Sitting ☐ Standing ☐ Walking ☐ Running ☐ Stairs ☐ Getting out of a car/chair ☐ Walking hills ☐ Bending ☐ Lifting ☐ Twisting ☐ Laying on back ☐ Laying on side ☐ Touching ☐ Laying on back ☐ Weather ☐ Other:

WHAT IMPROVES IT? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Shifting positions ☐ Bedrest ☐ Nothing

ANY OF THESE? ☐Numbness ☐Tingling ☐Bowel/Bladder Changes ☐Weakness ☐Loss Coordination ☐Valsalva

TREATMENT **RESULTS**

☐PT/Aqua Therapy:_____
☐Chiropractic:_____
☐Massage:_____
☐Acupuncture:_____
☐Pain Management:_____
☐Procedures:_____

	DIFFICULTIES WITH?	IMPROVED?
Activities/Daily Life	☐Yes ☐No	☐Yes ☐No
Level of Activity	☐Yes ☐No	☐Yes ☐No
Relief from last visit	☐Yes ☐No	☐Yes ☐No

PAIN MEDICATIONS **DURATION OF RELIEF**

☐Pain Meds:
☐Med Changes:
☐Side Effects:

STUDIES **DATE** **RESULT**

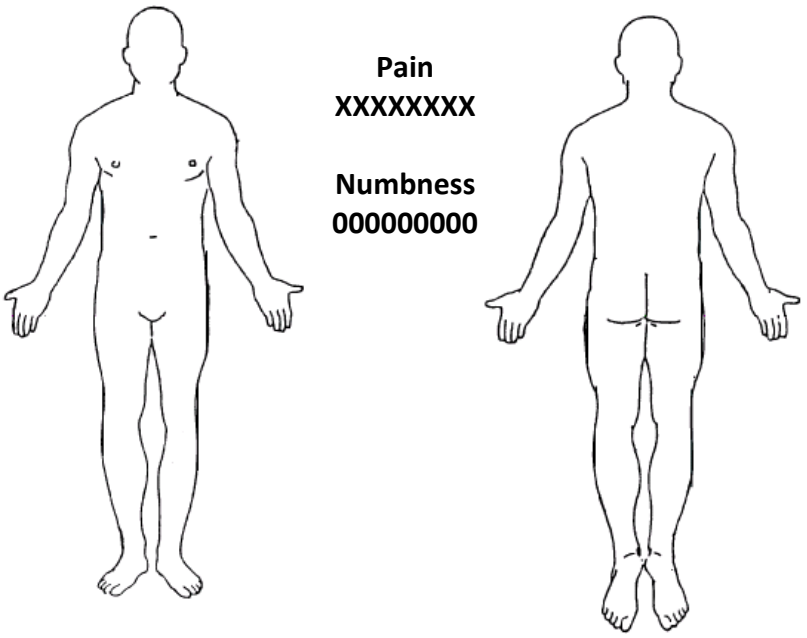
☐X-Ray
☐MRI
☐CT Scan
☐EMG
☐Bone Density
☐Other:

WHO WOULD YOU LIKE TO RECEIVE A COPY OF YOUR NOTES?:

☐Chiropractor ☐Physical Therapist
☐Other:_____

ADDRESS:

Draw the Location of Your Pain



Pain VAS for Arms and Legs

How much pain are you having in your arms and legs?
Please mark once on the line below using zero being no pain and ten being the worse pain you can imagine.

0 ——————————— 10

Pain VAS for Neck and Back

How much pain are you having in your neck and back?
Please mark once on the line below using zero being no pain and ten being the worse pain you can imagine

0 ——————————— 10