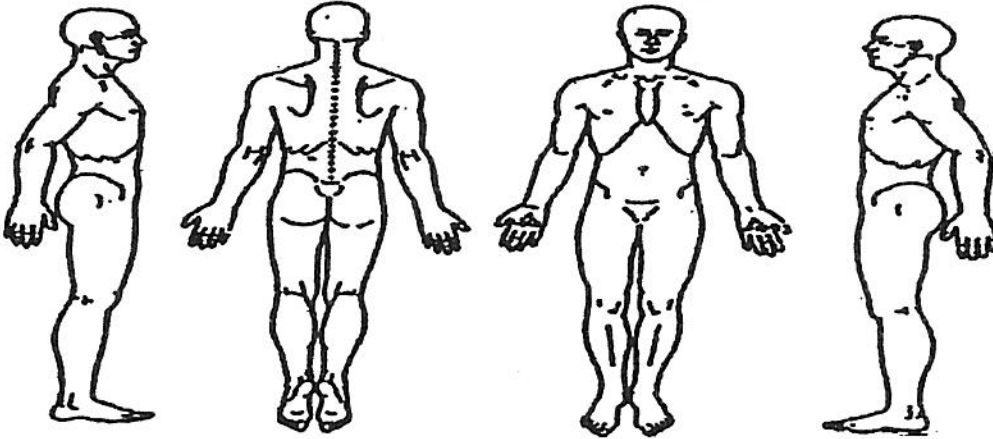


Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

PLEASE USE ONE OF THESE SHEETS PER BODY AREA (IE. NECK, MIDBACK, LOW BACK, ETC)

Indicate on the drawings below where you have pain and / or symptoms



How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp
- Dull
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Other: \_\_\_\_\_

How are your symptoms changing with time?

- Getting Worse
- Not Changing
- Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Who else have you seen for your problem?

- Another Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other \_\_\_\_\_
- No one

How long have you had this problem? \_\_\_\_\_

When did your symptoms get worse? \_\_\_\_\_

How do you think your problem began? \_\_\_\_\_

Do you consider this problem to be severe?

- Yes
- Yes, at times
- No

What makes your problem worse? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What concerns you the most about your problem / what does it prevent you from doing?

\_\_\_\_\_