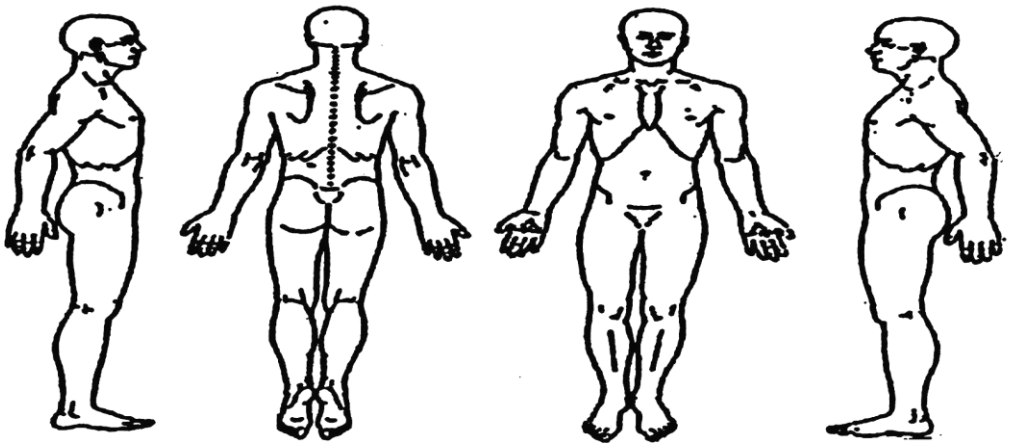
Name _____**Date of Birth**_____**Date** _____

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

How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Achy □ Sharp with motion
□ Burning □ Shooting with motion
□ Shooting □ Stabbing with motion
□ Stiff □ 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 □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other _____
□ Massage Therapist □ Physical Therapist □ 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?

_____