

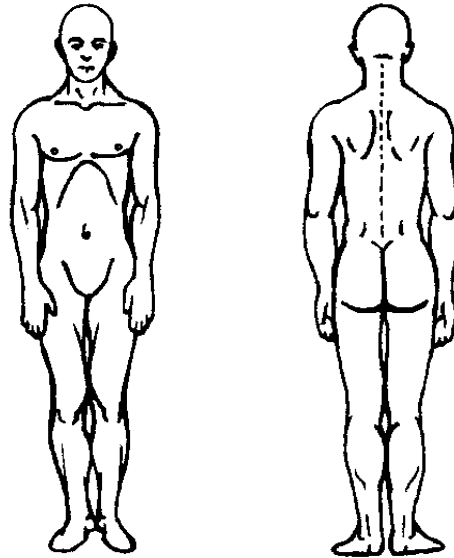
PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

1) _____ 2) _____ 3) _____ 4) _____
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CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = !!!
- Shooting = XXX
- Other _____ = ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Please describe any other activities that are restricted due to this injury? _____

Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you ever been diagnosed with a Subluxation? No Yes, When? _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: None

Surgical History: _____ None

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

DATE: ___/___/___

SIGNATURE: _____

PARENT/GUARDIAN: _____