Patients Name: _____ ***Pt. ID:*** _____ ***Date:*** _____

DO YOU KNOW WHAT CAUSED YOUR PROBLEM? _____

DO YOU NOTICE THE PAIN DRUING A CERTAIN TIME OF DAY? ☐MORNING ☐AFTERNOON ☐EVENING ☐IN THE MIDDLE OF THE NIGHT ☐WHEN YOU WAKE UP

HOW LONG HAVE YOU HAD YOUR SYMPTOMS? _____

INTENSITY: ☐MINIMAL ☐SLIGHT ☐MODERATE ☐SEVERE

IS YOUR CONDITION: ☐SAME ☐GETTING BETTER ☐GETTING WORSE

RATE YOUR PAIN: ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10**

0 BEING NO PAIN AND 10 BEING THE WORST PAIN IMAGINABLE

QUALITY: DESCRIBE YOUR PAIN?

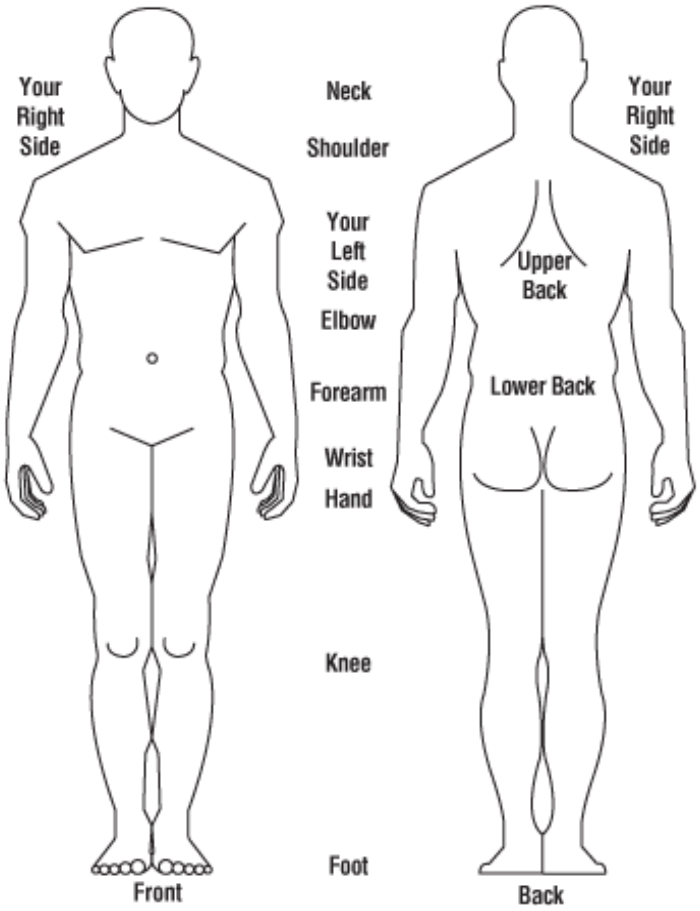
☐ACHING
☐BURNING
☐CRAMPING
☐DEEP
☐DULL
☐NUMB
☐RADIATING
☐SHARP
☐SHOOTING
☐SORE
☐STABBING
☐STIFF
☐SWELLING
☐TIGHT
☐TINGLING
☐THROBBING

WHAT ACTIVITIES ARE AFFECTED DUE TO THE PROBLEM?

☐BATHING
☐CARING FOR CHILDREN
☐CLEANING
☐CLIMBING STAIRS
☐COOKING
☐DOING LUANDRY
☐DRESSING
☐DRIVING
☐EXERCISING
☐GOING FROM LYING TO SITTING DOWN
☐GOING FROM SITTING TO STANDING
☐GROOMING
☐LAYING DOWN
☐LIFTING
☐SHOPPING
☐SITTING
☐SLEEPING
☐SOCIAL/REC
☐STANDING
☐STRETCHING
☐USING TECH.
☐USING PHONE
☐WALKING
☐WATCHING TV

RELIEVING FACTORS: WHAT MAKES THE PROBLEM BETTER?

☐NOTHING ☐EXCERCISE ☐PAIN KILLERS
☐ANTI-INFLAM'S ☐HEAT ☐REST
☐BRACING ☐ICE ☐STRETCHING
☐CHIROPRACTIC ☐MASSAGE ☐WALKING
☐ELEVATION ☐MOVEMENT ☐WRAPS



PLEASE MARK WHERE YOUR PAIN IS LOCATED

AGGRAVATING FACTORS: WHAT MAKES THE PROBLEM WORSE?

☐NOTHING ☐MOVEMENTS ☐BENDING ☐CARRYING THINGS ☐COUGHING ☐DRIVING
☐EATING ☐EXERCISE ☐STAIRS ☐HEAT ☐HOUSEWORK ☐ICE
☐JOGGING ☐LIFTING ☐LYING DOWN ☐PUSHING ☐RUNNING ☐SITTING
☐SLEEPING ☐SNEZZING ☐SQUATING ☐STANDING ☐TRAVELING ☐STRESS
☐STRETCHING ☐DEEP BREATHS ☐TURNING ☐TWISTING ☐WALKING ☐WORKING

WHAT TREATMENT(S) HAVE YOU TRIED FOR YOUR CONDITION?

☐NONE ☐MEDICATION ☐SURGERY ☐PHYSICAL THEREAPY ☐CHIROPRATIC ☐OTHER _____

Patients Signature: _____ ***Date:*** _____