

Today's	: Date:	

PATIENT BASIC INFORMATION

Nam	ne: FirstMILast
Date	e of Injury/Onset: Dominant Hand: Left / Right / Both
1.	Description of Accident/Injury/Onset Enter a full description of the accident, injury, or onset in the space below.
2.	Your condition during and immediately after injury/onset Enter the details of your condition during and immediately after your injury/onset.



	Today's Date:	
Patient Name:		

Description of Symptoms: (Describe symptoms below, in the order of severity if possible)

First Current S	ympto	m (Des	cribe o	nly ONE symp	tom pe	r sectio	on)				
1. Check on location below				2. Types of Pain:							
□Headaches	$\Box L$	$\Box R$	$\Box B$	□Dull	□Shar	:р 🗆	Aching	\Box Cutting			
Part of head:			□Throbbing	□Burr	ning 🗆	Numbing	□Tingling □	⊐Cramp	oing		
□Front □Top □ Back			□Spasm				□Pounding	□Const	ricting		
□Jaw	$\Box L$	$\Box R$	$\Box B$	Other:							-
□Eye	$\Box L$	$\Box R$	$\Box B$	3. Pain Freq	uency			6. Actions aff	fecting	this pair	1
□Neck	$\Box L$	$\Box R$	$\Box B$	□¼ of awak	e time 1	□ ¼ to [:]	½ time			Aggravates	
□Upper Back	$\Box L$	$\Box R$	$\Box B$	□½ to ¾ tim	ne □Mo	st all tł	ne time	□In the A.M.			
□Mid Back	$\Box L$	$\Box R$	$\Box B$	4. Pain Inter	nsity: Ho	ow doe	s it	□In the P.M.			
□Low Back	$\Box L$	$\Box R$	$\Box B$	affect your d	laily act	tivities	?	□Bend forwa			
□Chest	$\Box L$	$\Box R$	$\Box B$	□Doesn't Affe	ect □So	omewh	at Affects	□Bend back			
□Abdomen	$\Box L$	$\Box R$	$\Box B$	□Seriously Af	ffects □P	revent	s Activity	□Bend left			
□Ribs	$\Box L$	$\Box R$	$\Box B$	5. Does this	pain ra	diate ir	nto	□Bend right			
□Buttocks	$\Box L$	$\Box R$	$\Box B$	other body p	parts?			□Twist left			
□Shoulder	$\Box L$	$\Box R$	$\Box B$	Head	$\Box L$	$\Box R$	$\Box B$	□Twist right			
□Upper Arm	$\Box L$	$\Box R$	$\Box B$	Neck	$\Box L$	$\Box R$	$\Box B$	□Coughing			
□Forearm	$\Box L$	$\Box R$	$\Box B$	Shoulder	$\Box L$	$\Box R$	$\Box B$	□Sneezing			
□Hand	$\Box L$	$\Box R$	$\Box B$	Arm	$\Box L$	$\Box R$	$\Box B$	□Straining			
□Hip	$\Box L$	$\Box R$	$\Box B$	Hand	$\Box L$	$\Box R$	$\Box B$	□Standing			
□Leg	$\Box L$	$\Box R$	$\Box B$	Hip	$\Box L$	$\Box R$	$\Box B$	□Sitting			
□Foot	$\Box L$	$\Box R$	$\Box B$	Leg	$\Box L$	$\Box R$	$\Box B$	□Lifting			
□Other Location	ns:			Foot	$\Box L$	$\Box R$	$\Box B$	Other:			
				Other:							
Second Curren			escribe	only ONE sy		per sec	ction)				
1. Check on loc	ation	below		only ONE syl	Pain:	=	-				
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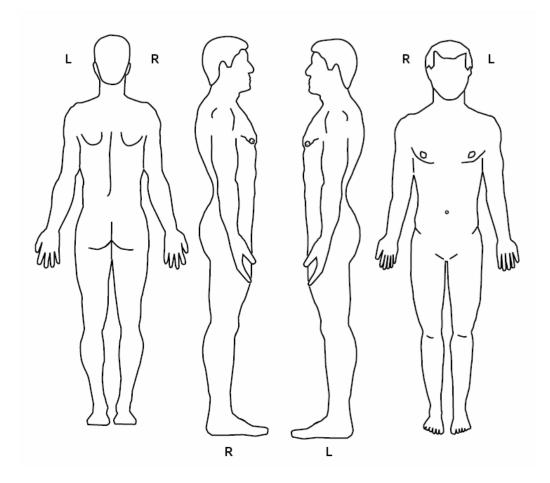


Pain Drawing

Name:	Date:	
Last, First	MM/DD/YYYY	

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----- Pins & Needles ooooo Burning Pain xxxxx Stabbing Pain /////// Aching Pain ((((((((



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain:

No Pain:	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
Right Now:	0	1	2	3	4	5	6	7	8	9	10	
Average Pain:	0	1	2	3	4	5	6	7	8	9	10	
At Best	0	1	2	3	4	5	6	7	8	9	10	
At Worst:	0	1	2	3	4	5	6	7	8	9	10	



Name:	Date:	
Last, First	MM/D	D/YYYY
Since your last visit to our office have you:		
Had any surgeries? If so explain below:		
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	· · · · · · · · · · · · · · · · · · ·	
Experienced any major trauma? If so explain below:		
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Experienced any sickness or illness? If so explain below:		
- 		
Started or stopped any new medications? If so explain below:		
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