REASON FOR VISIT

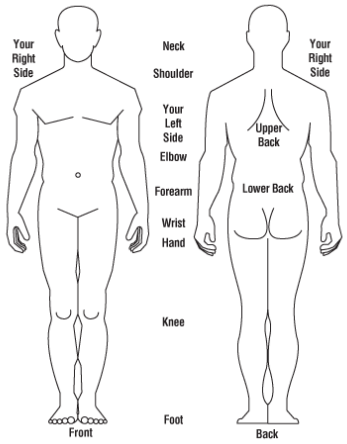
What is the reason for your visit today? __Headache __Neck Pain __Mid-Back Pain __Low Back Pain Other_____

What caused this complaint(s)?_____

When did this complaint begin? ____/____/____ **Is it getting worse?** __Yes __No __Constant __Comes and goes

Have you had this or similar complaint in the past? __Yes __No If "Yes", when?_____

What does your complaint(s) feel like? Circle all that apply: *Sharp /Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other* _____



Please circle or make an "X" on the body diagram to the left of where you have pain or other symptoms.

Area for Doctor's Notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain				*Moderate Pain*				*Worst Possible Pain*	
1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot or travel to? (if applicable)_____

What aggravates this complaint? Circle all that apply: *Sitting / Standing / Walking / Getting up from seat/ Walking Stairs Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending Forward / Bending Backward / Twisting / Reaching Lifting / Desk Work / Sneezing / Coughing / Everything / Unknown / Other:*_____

What relieves this complaint? Circle all that apply: *Sitting/ Standing / Walking /Resting / Exercise /Movement / Stretching Massage / Chiropractic / Heat / Ice / Laying Down / Medication / Nothing / Unknown / Other:*_____

How often do you experience your symptoms? __25% of the day __50% of the day __75% of the day __100% of the day

Timing of complaint: __Morning __As day progresses __Afternoon __Evening __While Sleeping __During activities __After activities __Symptoms are constant and do not change __Other:_____

With time, are your symptoms: __Improving __Worsening __Not changing

Have you seen other doctors for this complaint? __Yes __No If yes, please provide the following information:

Doctor's Name:_____ Date Consulted:_____ Diagnosis:_____

Is this condition interfering with your: Circle all that apply: *Sleep /Getting in or out of bed or chair / Personal Care / Travel Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:*_____

Is your complaint interfering with your daily activities? __Not at all __A little bit __Moderately __Quite a bit __Extremely

Name:_____ Date:_____