NAME: _____

REASON FOR VISIT:

_____

_____

Are you having difficulties performing daily activities? Yes No (circle one)

If yes, please explain: _____

Have you noticed *decreased* strength, range of motion, or other problems in any area of your body? Yes No (circle one)

Do you have any other symptoms or problems that you feel may or may not be related to your spine (*for example, acid stomach, skin rash, bowel difficulties*)? Yes No (circle one)

If yes, please explain: _____

Are you having pain? Yes No (circle one) *If YES please mark on the diagram where your pain is.*

PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Type of Pain: BURNING STABBING SHARP DULL CONSTANT COMES & GOES TINGLING NUMBNESS (circle one)

Do you feel BETTER WORSE SAME (circle one) since your last visit?

Other Comments or Concerns: _____

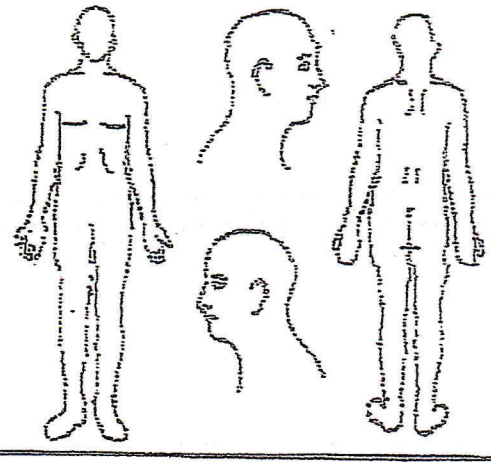
_____

_____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



SIGNATURE: _____ DATE: _____