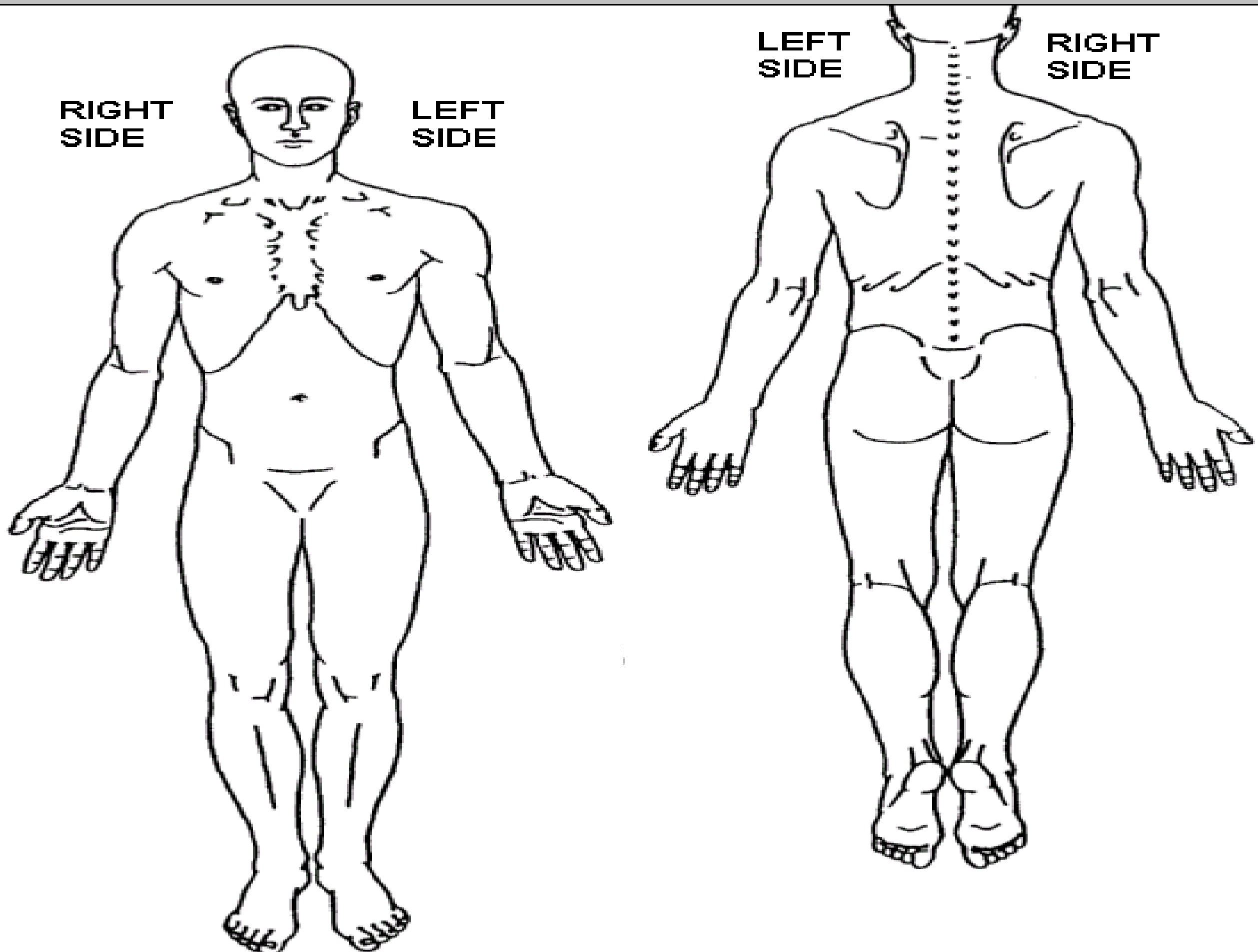
Patient Name: ______________________________ **Acct #:** ________________

SHADE THE AREAS OF YOUR BODY WHICH YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid- back Pain ☐ Low back Pain

☐ Other ____

What is your pain level today? (Circle)

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

How often are your symptoms present? ❑ 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Can you perform your daily activities? ❑ Yes ❑ No (Describe any current activity limitations) ____

Have you had spinal X-rays, MRI, CT Scan? ❑ No ❑ Yes Date(s) taken________________

What areas were taken? ____

Patient Signature: ______________________________ Date: ________________