

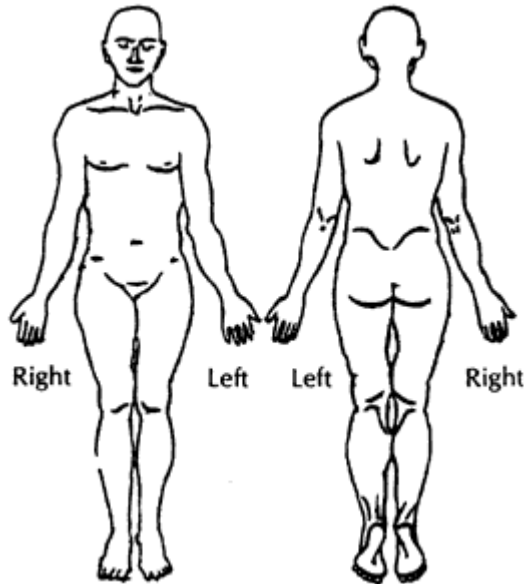
Name: _____
 (Print Please)

Date: ____ / ____ / ____

PAIN & INJURIES

Please fill out one of these sheets PER injury or area of pain. If your pain is generalized *and* the quality of the pain is consistent, one sheet is sufficient.

Please mark the area you are experiencing pain, numbness or swelling:



What makes the pain better?	
What makes the pain worse?	
Is this the first time you have experienced this pain in this area?	
Is this pain from an old injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please tell us about the original injury:
Does the pain radiate?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where to?
Is the pain better upon waking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the pain better in the evening?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the pain better or worse after exercise?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change

What is the quality of the pain? (check all that apply)	<input type="checkbox"/> Shooting <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Achy <input type="checkbox"/> General <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Burning
Does it feel better or worse with pressure/massage?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change
Does it feel better or worse with heat?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change
Does it feel better or worse with cold/ice?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change
How long has this pain been going on?	
Have you tried: (check all that apply)	<input type="checkbox"/> Chiropractic made it <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> PT made it <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change <input type="checkbox"/> Massage made it <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change Notes:
What medications, vitamins or herbs are you taking <i>(Please list all)</i> →	1. 2. 3. 4. 5. 6. 7.
<u>IMPORTANT!</u> **Do you have a pacemaker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
GENERAL HEALTH:	
How would you describe your levels of stress:	
How do you deal with your daily stress?	
How do you sleep?	
	Do you have problems falling sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you stay asleep throughout the night? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wake feeling refreshed? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you snore or have sleep apnea? <input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise	What do you do? How often? Do you feel better when you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> It depends (please explain)