Getting you back to a happy and peaceful state of mind.

Patient Name: _____ Treatment Date: _____
First Middle Last

Therapist: _____ Duration of Treatment: _____

SUBJECTIVE

Intensity of Pain: *(circle one)* 1 2 3 4 5 6 7 8 9 10

Sensation of pain:

Dull	Sharp
Cold	Burning
Tender	Aching
Itching	Cramping
Sensitive	Radiating
Throbbing	Shooting
Tingling	Pressure
Stiff	
Other: _____	

Time Pattern of Pain:

Constant (pain does not change)
Intermittent (intensity doesn't change but comes and goes)
Variable (intensity changes throughout the day)

This pain prevents you from participating in:

Leisure Activities	Work
Sports/exercise	Sleep
Other: _____	

When did the pain start? _____

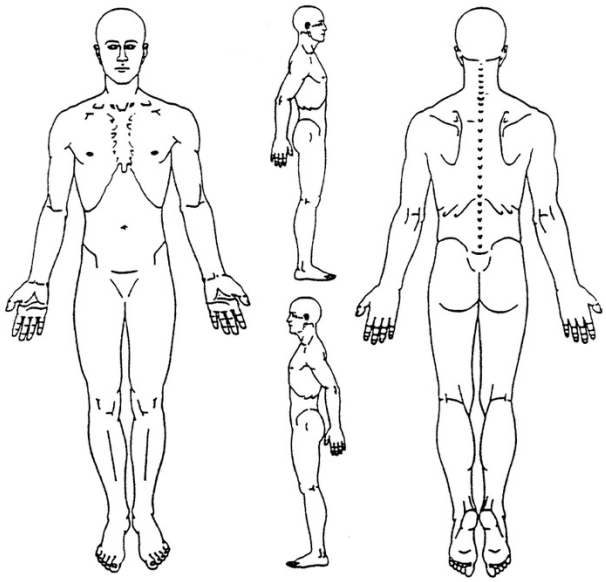
_____

Was there a specific incident that caused this pain? _____

Motor Vehicle Accident	Fall
Slept Funny	Work
Sports/exercise	
Other: _____	

Have you seen other practitioners about this issue?

Massage Therapist	Chiropractor
Physical Therapist	Physician
Other: _____	



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