Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of pain: __ Sharp __ Dull __Burning __ Aching __ Shooting __Stabbing __ Stiffness

___Cramps __Tingling __Throbbing __Numbness __Swelling __Other:_____

How often do you have this pain? _____ Is the Pain constant or come and go_____

Dose the pain interfere with: __Work __Sleep __Daily Routine __Recreation

Activities or movements that are painful to perform: __Sitting __Standing __Walking __Bending __Lying Down ___Sleeping

HEALTH HISTORY

Name, address and specialty of other doctors who have treated you for this condition:

_____

Check any of the following conditions that you have now or have had in the past:

__AIDS/HIV __Stroke __Glaucoma __High Cholesterol __Bleeding Disorders

__Allergies __Cancer __Heart Disease __Kidney Disease __Pacemaker

__Anemia __Diabetes __Hepatitis __Liver Disease __Parkinson's Disease

__Arthritis __Hernia __Headaches __Prosthesis ___Breathing Problems

__Asthma __Epilepsy __Herniated Disc __Multiple Sclerosis __Osteoporosis

__Fractures __Thyroid Problems __Tuberculosis __Tumors/Growths

__High Blood Pressure ___Depression

EXERCISE LEVEL: ___None ___Light ___Moderate ___Heavy ___Daily

WORK ACTIVITY: ___None ___Sitting ___Standing ___High Stress Level

___Light Labor ___Heavy Labor ___Office Work ___Computer

DO YOU: Smoke _____ Packs/Day: _____

Drink Alcohol _____ Drinks/Week: _____

Drink Coffee/Soda _____ Cups/Day: _____

Do you have a high stress level at Home _____

Are you pregnant? _____ Due Date: _____

Any previous: ___Accidents/Falls ___Broken Bones ___Dislocations ___Surgeries

Explain:_____

_____

Please list the names and reasons of any prescription or over the counter medications you are taking: _____

Vitamins/Herbs/Minerals: _____

Signature: _____ Date:_____

Parent or Guardian (if Patient is under 18) Signature _____ Date _____