Reason for your Visit

Patient's Name _____ Date of Birth: _____

Current Complaints: ❒Headaches /❒Neck pain /❒Mid-back pain / ❒Low back pain /❒Other _____

When did your symptoms begin? _____ How did they start? _____

Activities or movements that are painful to perform: ❒Sitting ❒ Standing ❒Walking ❒Bending ❒Lying down

How often do you experience your symptoms?

- ❒ Constantly (76-100% of the day)
- ❒ Frequently (51-75% of the day)
- ❒ Occasionally (26-50% of the day)
- ❒ Intermittently (0-25% of the day)

Describe the nature of your symptoms

❒ Sharp ❒ Shooting
❒ Dull ache ❒ Burning
❒ Numb ❒ Tingling

How are your symptoms changing?

❒ Getting better
❒ Not changing
❒ Getting Worse

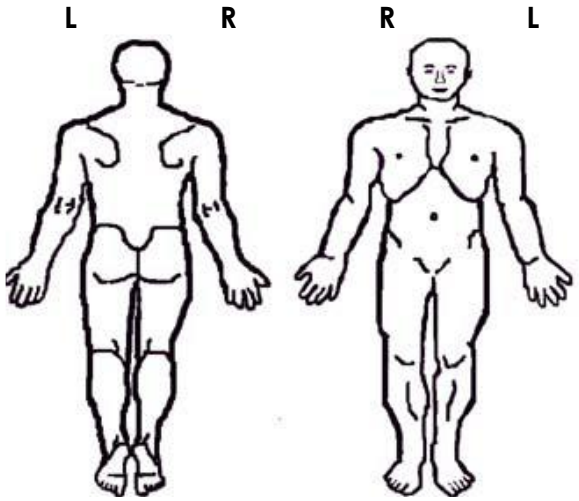
Have you had any new complaints/conditions? ❒No ❒Yes ❒Initial visit (for new patients only)

Have you had any re-injuries or events that have prolonged your recovery? ❒No ❒Yes
If Yes, Explain: _____
_____

How do your symptoms affect your ability to perform activities? **Circle below**

No complaints	mild with activity	moderate, interferes with activity	limiting, prevents full activity	Intense, preoccupied with seeking relief	Severe, no activity possible

	None										unbearable
How bad are your symptoms?	0	1	2	3	4	5	6	7	8	9	10



Signature: _____ Date: _____