***Name*_____*Date*_____**

Please fill out this form completely. For areas with no complaint please write NONE.

Doctor's Notes _____

Neck

Do you have a neck complaint: Yes or No
Describe the pain(sharp, dull, ache, stabbing)_____
Frequency of symptom(circle one)? 0-25% of the time, 25-50%, 50-75%, 75-100%
Does the pain radiate? (into arms, hands, etc)_____
Does anything seem to make the pain worse?_____
Does anything seem to help the pain?_____
Rate the intensity of pain from 1-10 (10 = extreme pain, 1=very mild pain)_____
When is the pain most noticeable?_____

Headache and/or Migraine (please circle)

Do you have headaches/migraines? Yes or No
What part of your head? _____
Describe the headache(ache, dull, throbbing, stabbing, etc.)_____
How often do you get a headache/migraine?_____
Does anything seem to make the headache worse? _____
Does anything seem to help the headache?_____
Rate the intensity of pain from 1-10. (10 = extreme pain, 1=very mild pain)_____

Upper back pain and/or Mid back pain (please circle)

Do you have a midback complaint: Yes or No
Describe the pain(sharp, dull, ache, stabbing)_____
Frequency of symptom(circle one)? 0-25% of the time, 25-50%, 50-75%, 75-100%
Does the pain radiate? (around your back, into your neck) _____
Does anything seem to make the pain worse?_____
Does anything seem to help the pain?_____
Rate the intensity of pain from 1-10. (10 = extreme pain, 1=very mild pain)_____
When is the pain most noticeable?_____

Low back pain

Do you have a low back complaint: Yes or No
Describe the pain(sharp, dull, ache, stabbing)_____
Frequency of symptom(circle one)? 0-25% of the time, 25-50%, 50-75%, 75-100%
Does the pain radiate? (into legs, feet, etc) _____
Does anything seem to make the pain worse?_____
Does anything seem to help the pain?_____
Rate the intensity of pain from 1-10 (10 = extreme pain, 1=very mild pain)_____
When is the pain most noticeable?_____
Do you have problems with bowel/bladder control?_____

Arms/hands and/or Legs/Feet (please circle)

Do you have any extremity complaints: Yes or No
Which side: Left, Right or Both _____
Describe the pain (sharp, dull, ache, stabbing)_____
Frequency of symptom(circle one)? 0-25% of the time, 25-50%, 50-75%, 75-100%
Does anything seem to make the pain worse?_____
Does anything seem to help the pain?_____
Rate the intensity of pain from 1-10 (10 = extreme pain, 1=very mild pain)_____
When is the pain most noticeable?_____

Are there any other health issues you would like to discuss with us? Please give details:_____

_____

Does your pain interfere with your daily activities? If so, which activities?_____

_____

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