

core

CHIROPRACTIC CENTER

149 Iron Point Road • Folsom, CA 95630
916-989-1014

Patient Name _____

Patient# _____ Date _____

Using the key below, indicate on the body diagrams where you are experiencing these symptoms:

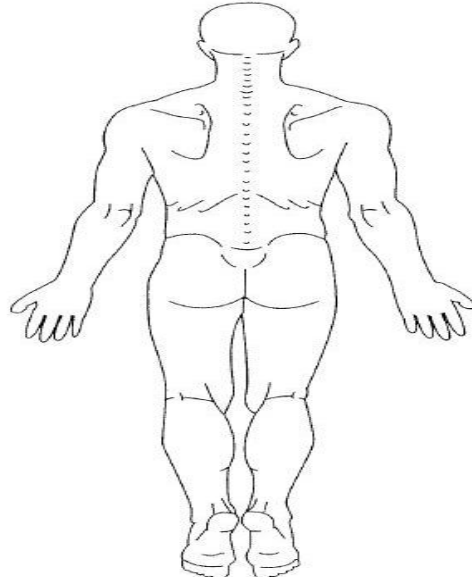
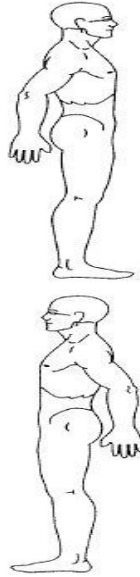
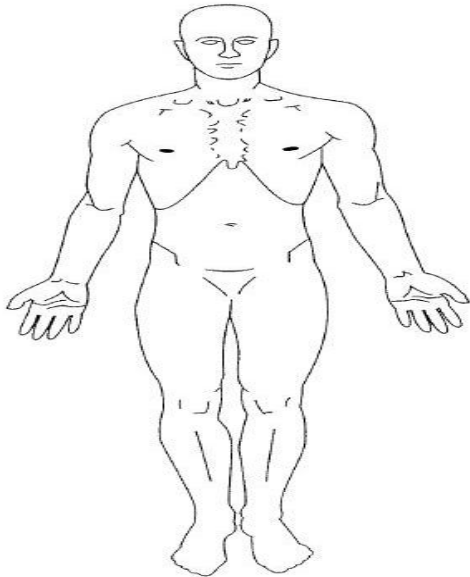
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work-related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Intermittently
(26-50% of the day)

Occasionally
(0-25% of the day)

What describes the nature of your symptoms?

Sharp
Burning

Ache
Tingling

Numb
Throbbing

Shooting
Other _____

How are your symptoms changing? ___ getting better ___ not changing ___ getting worse

Which of the following activities of daily living are restricted / impossible for you to perform due to the nature of your condition and/or pain? (Please circle ALL that apply) If > 5, then complete ADL form.

sleeping
exercise
gardening
hygiene

lying down
vacuuming
working
bathing

standing
dusting
driving
intercourse

walking
lifting
eating
dressing

sitting
doing dishes
bending
urination

Patient/Guardian Signature: _____ Date: _____