core
FINNELL CHIROPRACTIC

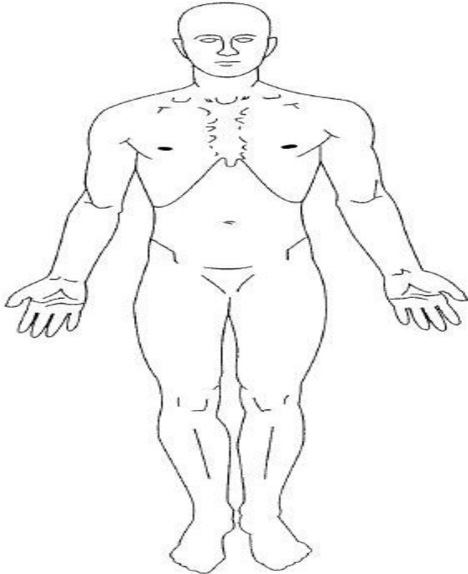
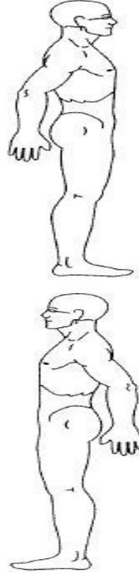
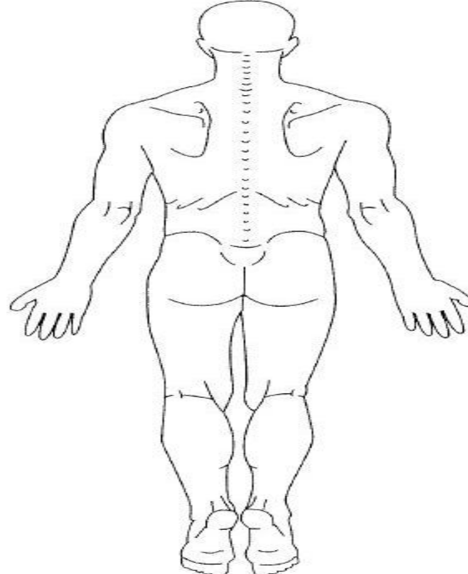
149 Iron Point Road • Folsom, CA 95630
916-989-1014

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 Ache Numb Shooting
Burning Tingling Throbbing 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	lying down	standing	walking	sitting
exercise	vacuuming	dusting	lifting	doing dishes
gardening	working	driving	eating	bending
hygiene	bathing	intercourse	dressing	urination

Patient/Guardian Signature: ____________________________ Date: _______________________