

SYMPTOMS If Your Symptoms **HAVE NOT** Changed Since Your Last Visit Indicate Here and Proceed to Section II
 If Your Symptoms **HAVE** Changed Since Your Last Visit Please Complete Both Sections I and II

SECTION I

RIGHT SIDE	Symptoms							Severity			Frequency				Improvement									
	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Stinging	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Head	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Neck	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Upr Back	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Mid Back	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Low Back	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Shoulder	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Elbow	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Wrist	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Hand	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Hip	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Knee	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Ankle	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Foot	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R

LEFT SIDE

LEFT SIDE	Symptoms							Severity			Frequency				Improvement									
	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Stinging	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Head	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Neck	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Upr Back	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Mid Back	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Low Back	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Shoulder	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Elbow	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Wrist	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Hand	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Hip	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Knee	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Ankle	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R
Foot	P	N	T	S	S	S	W	M	M	S	B	D	S	S	S	T	O	I	F	C	I	W	U	R

SECTION II

How Would You Rate Your Pain Today With 0 Being The Best And 10 Being The Worst

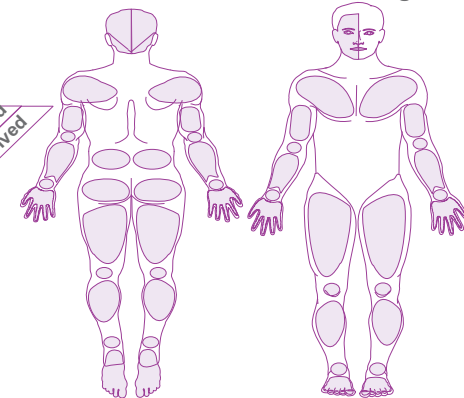
0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Possible

If Your Symptoms Change, When Are They Worse

- Morning Evening Afternoon
- Night Other _____

PAIN DIAGRAMS Please Mark The Location Of Your Pain On These Figures



- No New Aggravation / Injury
- New Injury _____

PATIENT SIGNATURE: _____ **DATE:** _____
