ALLIANCE CHIROPRACTIC CENTER
AND ACUPUNCTURE

Name: _____ Date: _____

Symptoms: _____

Severity: No Pain- **0 1 2 3 4 5 6 7 8 9 10** -Worst Imaginable

Frequency (% of the day present) _____

Character (How it feels) _____

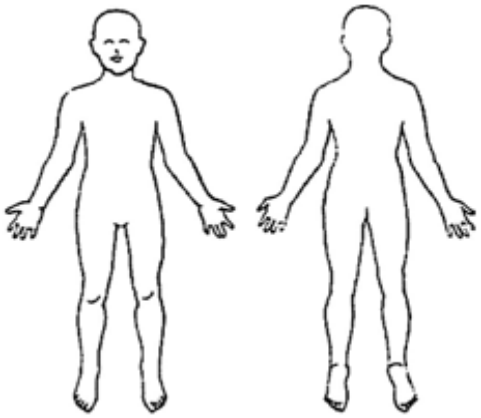
When did your symptoms begin? _____

How did your symptoms begin? _____

_____

Have you had it before? When? _____

_____



Additional symptoms? _____

_____

Does your pain radiate? Where? _____

Is your condition improving, getting worse, or not changing? _____

What makes you feel BETTER? (Even a little) _____

What makes your pain WORSE? _____

What treatments have you tried? Result? _____

Have you seen anyone else for this problem? _____

What are you having trouble doing? _____

What can you NOT do at all because of pain? _____

Have you missed work or school? How many days? _____

Anything else we should know regarding this issue or your health? _____

_____

Signature: _____ Date: _____