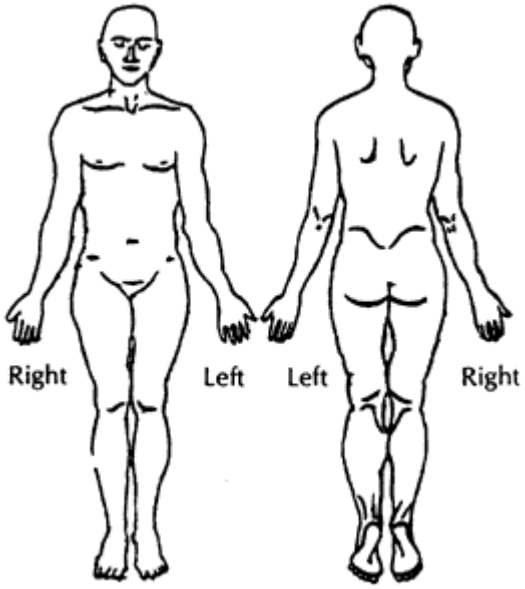
Name: _____ Date: ____ / ____ / ____
(Print Please)

PAIN & INJURIES

Area of discomfort:



What makes the pain better?	
What makes the pain worse?	
Is this the first time you have experienced this pain in this area?	
Is this pain from an old injury?	□ Yes □ No If yes, please tell us about the original injury:
Does the pain radiate?	□ Yes □ No If yes, where to?
Is the pain better upon waking?	□ Yes □ No
Is the pain better in the evening?	□ Yes □ No
Is the pain better or worse after exercise?	□ Better □ Worse □ No change

What is the quality of the pain? (check all that apply)	□ Shooting □ Stabbing □ Dull □ Throbbing □ Achy □ General □ Numbness □ Tingling □ Burning
Does it feel better or worse with pressure/massage?	□ Better □ Worse □ No change
Does it feel better or worse with heat?	□ Better □ Worse □ No change
Does it feel better or worse with cold/ice?	□ Better □ Worse □ No change
How long has this pain been going on?	
Have you tried: (check all that apply)	□ **Chiropractic** made it □ Better □ Worse □ No change □ **PT** made it □ Better □ Worse □ No change □ **Massage** made it □ Better □ Worse □ No change Notes:
What medications, vitamins or herbs are you taking (***Please list all)*** →	1. 2. 3. 4. 5. 6. 7.
IMPORTANT! ****Do you have a pacemaker?**	□ **Yes** □ **No**
GENERAL HEALTH:	
How would you describe your levels of stress:	
How do you deal with your daily stress?	
How do you sleep?	
	Do you have problems falling sleep? □ Yes □ No Do you stay asleep throughout the night? □ Yes □ No Do you wake feeling refreshed? □ Yes □ No Do you snore or have sleep apnea? □ Yes □ No
Exercise	What do you do? How often? Do you feel better when you exercise? □ Yes □ No □ It depends (please explain)