



Name: _____ Date: _____ Next Physician Appointment: _____

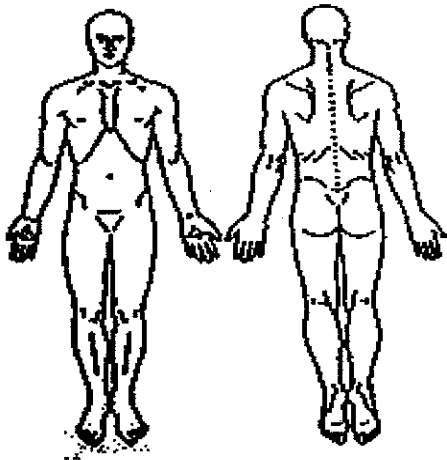
Was this problem a result of injury? Yes No

Have you had a recent flare-up or increase in your symptoms? Yes No

Have you had or do you have any of the following?

- | | | |
|---------------------------|-----|----|
| Diabetes | Yes | No |
| Chronic Headaches | Yes | No |
| Previous Physical Therapy | Yes | No |
| Dizziness | Yes | No |
| Currently Pregnant | Yes | No |
| Chiropractic Visit | Yes | No |
| Massage Therapy | Yes | No |
| Cortisone Allergies | Yes | No |
| Pacemaker/Defibrillator | Yes | No |
| Cancer | Yes | No |
| Allergic to Latex | Yes | No |

Please circle on the scale below your level of pain today.



0 = No Pain 10 = Pain that would make you go to the emergency room

1 2 3 4 5 6 7 8 9 10

Please indicate on the drawing the location(s) of your pain: