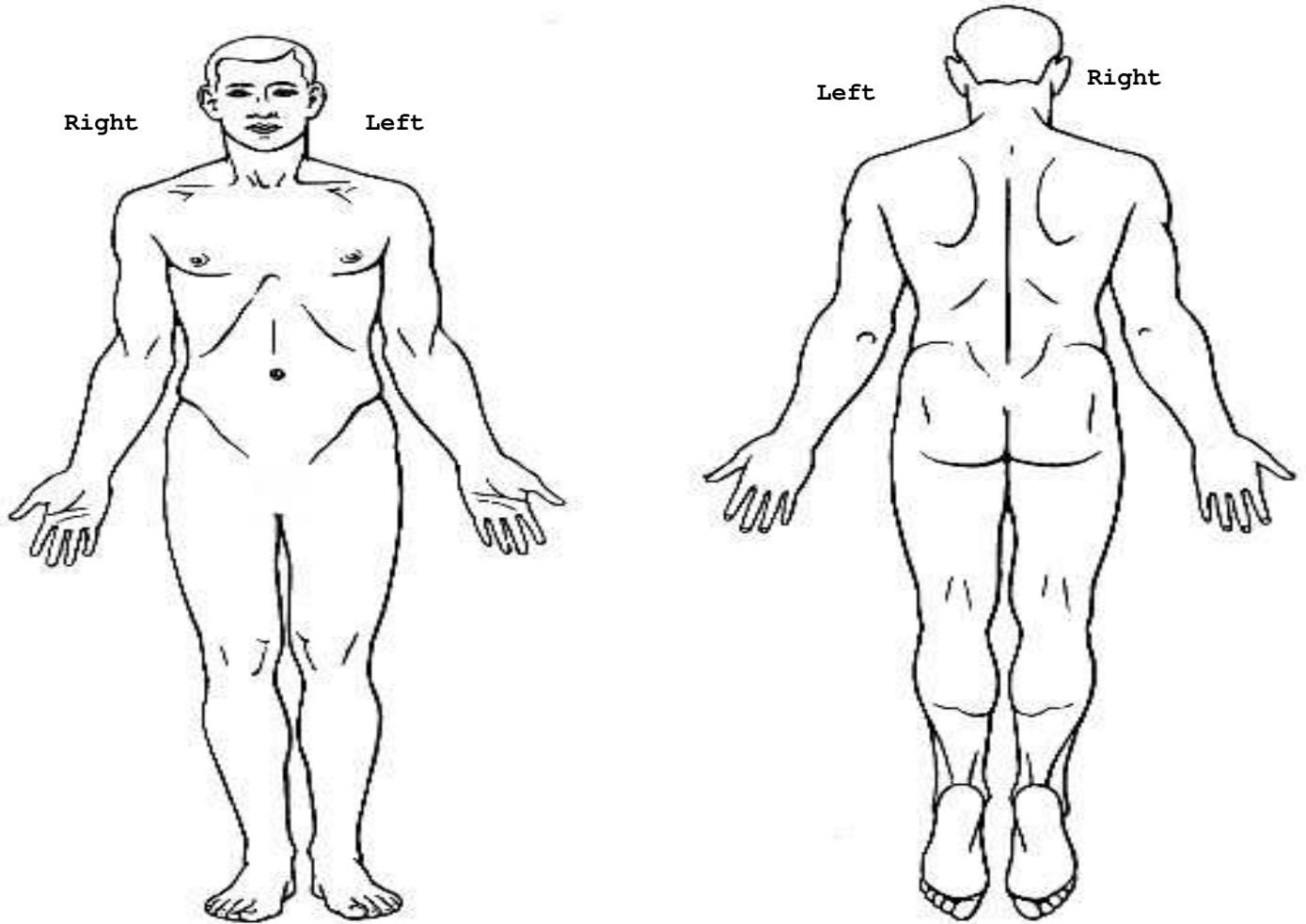


Patient Name: _____

Date: _____

If you have pain or numbness:

Please mark an "X" on the body part(s) where you have **pain**,
an "0" on the body part(s) where you have **numbness**.



Pain Scale: (Please circle the appropriate number or phase)

	No Pain	Moderate Pain						Severe Pain			
	↓					↓				↓	
Typically, my pain level is:	0	1	2	3	4	5	6	7	8	9	10
At its worst, my pain level is:	0	1	2	3	4	5	6	7	8	9	10
At its best, my pain level is:	0	1	2	3	4	5	6	7	8	9	10

My leg pain is, Worse than Same as Less than, my back pain.

My arm pain is, Worse than Same as Less than, my neck pain.

Review of Systems

In the past month, have you experienced any of the following? Please put a check mark in front of any/all of the following that you have experienced. If you have experienced any of the symptoms, please be sure to notify your family doctor.

HEENT

- Blurred vision
- Dry Eyes
- Hard of hearing
- Nasal Congestion
- Sore Throat
- Cough
- Other: _____

PULMONARY

- Shortness of breath
- Other: _____

ABDOMINAL

- Abdominal Pain
- Other: _____

INTEGUMENTARY

- Moles
- Skin Rash
- Other: _____

NEUROLOGIC

- Tremors
- Other: _____

GASTROINTESTINAL

- Constipation
- Diarrhea
- Other: _____

CARDIOVASCULAR

- Chest pain
- Other: _____

GENERAL

- Fevers
- Chills
- Night sweats
- Stress
- Poor sleep
- Swelling of feet
- Swollen glands
- Problems with blood clots
- Weight Loss
- Weight Gain
- Other: _____

WORK STATUS:

- Full-time
- Part-time
- Not Working
- Regular Duty
- Modified Duty with restrictions

Restrictions: _____

MEDICATIONS: Please list all the medications you are currently taking.

Please Note: This must be completed each time you visit our office, or you may bring a list for us to photocopy. **Do not write "same as last time."**

Medication	Dosage	Times Per Day	Medication	Dosage	Times Per Day

Patient Signature: _____