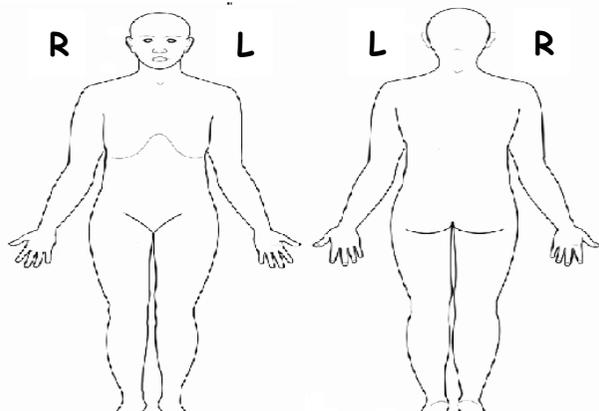




## How Can We Help You?

| PLEASE LIST YOUR CURRENT ISSUES (most severe first) | SEVERITY (1 - 10)<br>1=mild-10=severe | QUALITY OF PAIN (eg: sharp, dull, burning, ache, constant or intermittent) | DO YOU EXPERIENCE REFERRED PAIN (shooting, pain, pins & needles or numbness)? | WHEN & HOW DID THE ISSUE BEGIN? | ANY AGGRAVATING OR RELIEVING FACTORS?<br><br>What makes it better or worse? | HAVE YOU HAD THIS CONDITION BEFORE?<br>When? | HAVE YOU RECEIVED ANY CARE OR TREATMENT FOR THIS ISSUE TO DATE? |
|---|---------------------------------------|--|---|---------------------------------|---|--|---|
| 1.  |                                       |  |   |                                 |   |  |   |
| 2.  |                                       |  |   |                                 |   |  |   |
| 3.  |                                       |  |   |                                 |   |  |   |

Please mark the areas of discomfort



Chiropractor's Comments

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