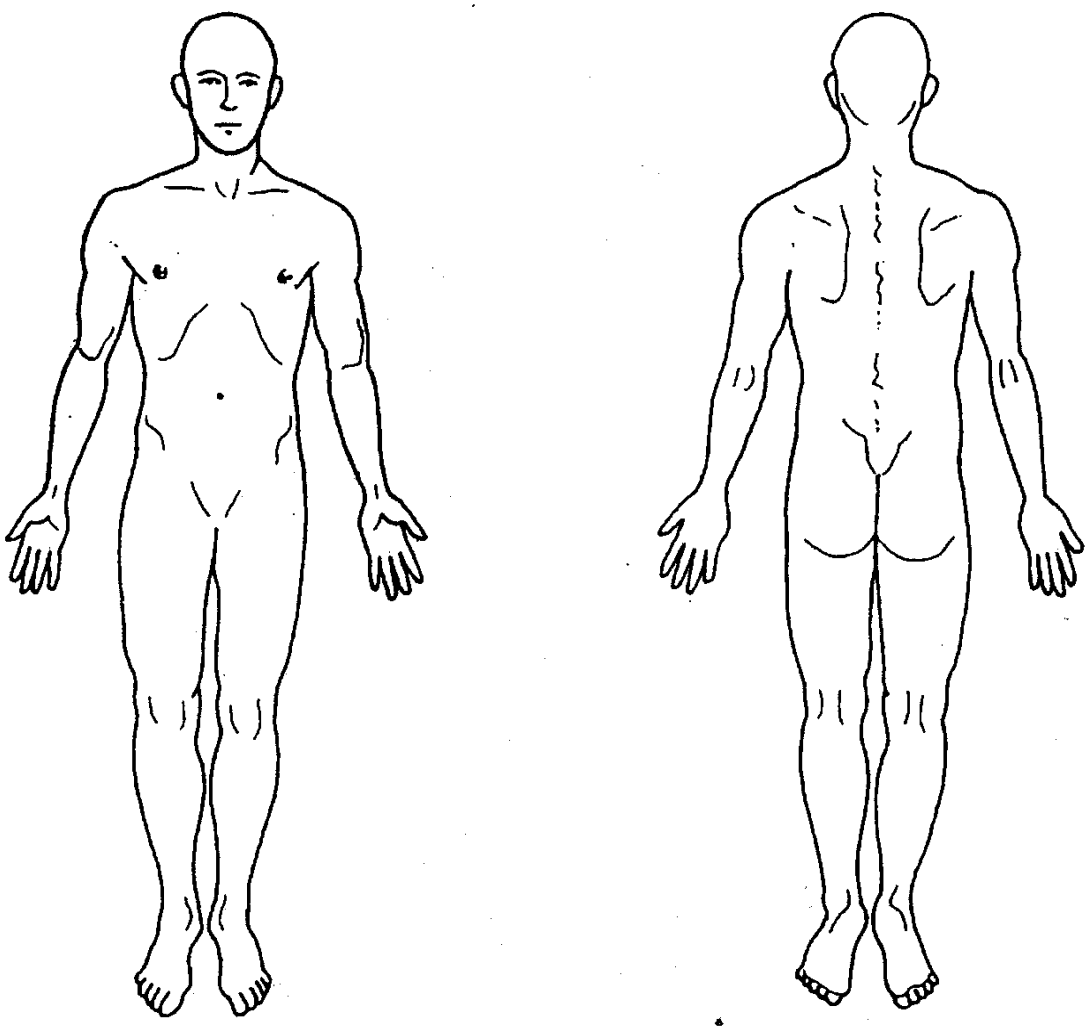
Name: _____ **Date:** _____

1. Mark exactly where your pain or symptoms are located.
Please draw the symbols to indicate the type and location of symptoms on the model below.

! Throbbing **#** Pounding **%** Shooting **&** Stabbing **^** Knifelike **=** Burning **@** Deep Ache **$** Sickening
~ Burning ***** Tingling **$** Dull **+** Unbearable



2. Pain Scale: Mark your pain level on a scale of 1 to 10

0 ☺

10 ☹

3. Please list any difficulties you are experiencing at home or work:
Lifting heavy objects, standing, etc.

_____
_____

4. What best describes the cause of your symptoms? Please circle.

Accident/Injury Gradual Onset Don't know Other

5. When did your symptoms begin?
Auto accident, chronic illnesses, etc.

_____
_____

6. Medications:
What medications are you currently taking? Please include all prescriptions and non-prescriptions (over the counter vitamins, herbs, minerals, etc.)

_____
_____