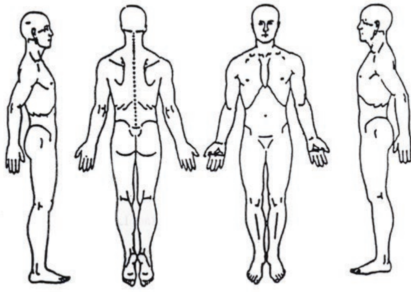
Describe your Complaint/Problem/Injury
Mark areas of pain/discomfort



____

Is this interfering with your: ☐ Work ☐ Sleep ☐ Exercise ☐ Daily Activities ☐ Other: ____________

Which activities aggravate your condition?
☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Coughing ☐ Sneezing ☐ Driving ☐ Exercise ☐ Other: ____________

Which activities relieve your condition?
☐ Rest ☐ Moving About ☐ Cold Pack ☐ Heat

Other professionals consulted for this condition?

____

When did this problem begin?

____

Have you had this in the past? ____________
When? ____________

Is it getting: ☐ Worse ☐ Same ☐ Better

Pains are: ☐ Sharp ☐ Dull ☐ Achy ☐ Stabbing

Medical Tests, X-rays, MRI or CT scans for this condition?

____

Other health problems? ____________

Pain Scale: On a scale of **0** (no pain) to **10** (worst pain ever), how do you rate your pain level:

Right now: 0 1 2 3 4 5 6 7 8 9 10 **At its Worst:** 0 1 2 3 4 5 6 7 8 9 10 **At its Best:** 0 1 2 3 4 5 6 7 8 9 10

Medication/Drugs/Pain Killers you now use: ____________

Circle any of the following that affect you: Diabetes Cancer Asthma Fractures Heart Disease Heart Attack High/Low Blood Pressure Psychological Disorder Epilepsy Fainting Hepatitis Lupus Unexplained Weight Loss Osteoporosis Arthritis Seizures

WE ACCEPT PAYMENT BY CASH, CHEQUE, CREDIT CARD AND DEBIT

I understand that all services are to be paid in full at the time of service and
I am responsible for billing my private insurance, if necessary.

Date: ____________ **Signature of Patient/Guardian:** ____________