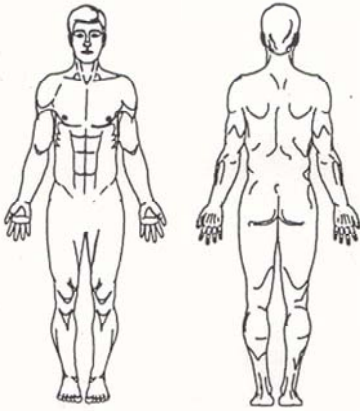


PLEASE be thorough & fill out COMPLETELY

Date: _____

Name: _____

Symptom Localization



P ___ Pain T ___ Tender
 N ___ Numb t ___ Tingling
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

ARE YOU PREGNANT?

Yes No

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- _____

What else have you tried to alleviate your pain? _____

How does your injury interfere with your:
 Social Life _____

Work _____

Family _____

How will your life improve when your health improves? _____

PLEASE CHECK OFF ALL THE BOXES THAT APPLY TO YOU

ATLAS	<input type="checkbox"/> Headaches <input type="checkbox"/> Nervousness <input type="checkbox"/> Insomnia <input type="checkbox"/> Nausea
AXIS	<input type="checkbox"/> Dizziness <input type="checkbox"/> Confusion <input type="checkbox"/> Fainting <input type="checkbox"/> Head Colds
CERVICAL SPINE	<input type="checkbox"/> Chronic tiredness <input type="checkbox"/> High blood pressure
1st THORACIC	<input type="checkbox"/> Stress problems <input type="checkbox"/> Allergies <input type="checkbox"/> Ear ache
	<input type="checkbox"/> Deafness <input type="checkbox"/> Blurry vision
	<input type="checkbox"/> Acne or pimples <input type="checkbox"/> Nerve pain&/ or inflammation
	Hay fever <input type="checkbox"/> Hearing loss <input type="checkbox"/> Runny nose
	<input type="checkbox"/> Sore throat <input type="checkbox"/> Laryngitis <input type="checkbox"/> Hoarseness of throat
	<input type="checkbox"/> Neck pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Tonsillitis
	<input type="checkbox"/> Upper arm pain
	<input type="checkbox"/> Colds <input type="checkbox"/> Thyroid conditions <input type="checkbox"/> Bursitis
THORACIC SPINE	<input type="checkbox"/> Lower arm(s) & hand(s) pain <input type="checkbox"/> Asthma <input type="checkbox"/> Cough
	<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Chest pain <input type="checkbox"/> Functional heart conditions
	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chest congestion
	<input type="checkbox"/> Mid back pain <input type="checkbox"/> Gallbladder problems <input type="checkbox"/> Jaundice
	<input type="checkbox"/> Liver problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Poor circulation
	<input type="checkbox"/> Pain between the shoulders <input type="checkbox"/> Fevers
	<input type="checkbox"/> Stomach troubles <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn
	<input type="checkbox"/> Poor appetite <input type="checkbox"/> Ulcer <input type="checkbox"/> Gastritis
	<input type="checkbox"/> Lowered resistance <input type="checkbox"/> Spleen problems
1st LUMBAR	<input type="checkbox"/> Allergies <input type="checkbox"/> Hives
	<input type="checkbox"/> Chronic tiredness <input type="checkbox"/> Kidney problems
	<input type="checkbox"/> Hardening of the arteries
	<input type="checkbox"/> Skin conditions <input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Bolls
	<input type="checkbox"/> Rhemmatism <input type="checkbox"/> Sterility <input type="checkbox"/> Gas pain
	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Colitis <input type="checkbox"/> Hernias
LUMBAR SPINE	<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Abdominal cramps
	<input type="checkbox"/> Varicose veins <input type="checkbox"/> Appendicitis
	<input type="checkbox"/> Bladder problems <input type="checkbox"/> Menstrual cramps
	<input type="checkbox"/> Impotency <input type="checkbox"/> Irregular periods
	<input type="checkbox"/> Bed wetting <input type="checkbox"/> Knee pain <input type="checkbox"/> Miscarriages
	<input type="checkbox"/> Low back pain <input type="checkbox"/> Pain down the leg(s)
	<input type="checkbox"/> Difficult, painful or frequent urination
SACRUM & COCCYX	<input type="checkbox"/> Weakness in leg (s) <input type="checkbox"/> Poor circulation in leg (s)
	<input type="checkbox"/> Leg cramps <input type="checkbox"/> Cold feet <input type="checkbox"/> Weak or swollen ankles
	<input type="checkbox"/> Walking problems <input type="checkbox"/> Spinal curve problems
	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Itching <input type="checkbox"/> Tail bone pain

Other symptoms or conditions you would like the doctor to know about: _____

Patient signature: _____