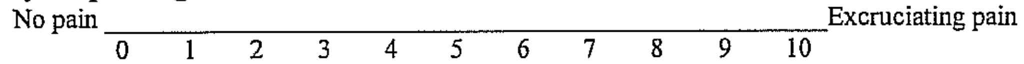
CLARK
CHIROPRACTIC
"We care about your health."

Name:______________________________ Date______________________

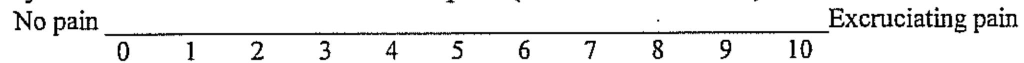
What is your current weight: ________lbs., and height, ______ft. ______in.

Chief Complaint:____

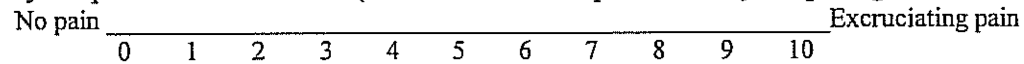
What is your pain right now?



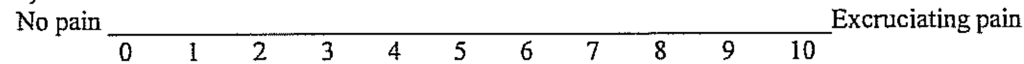
What is your **TYPICAL** or **AVERAGE** pain (over the last week)?



What is your pain AT ITS **BEST** (How close to "no pain" does your pain get at its best)?



What is your pain AT ITS **WORST** (How close to "excruciating" does your pain get at its worst)?



Comments:______________________________

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X NUMBNESS
+ BURNING
O PIN & NEEDLES
= STABBING

Patient Signature:______________________________ Date:__________