Date: __/__/__ Name: _____

Age:_____ Height.:_____ Weight:_____

Why are you here: _____

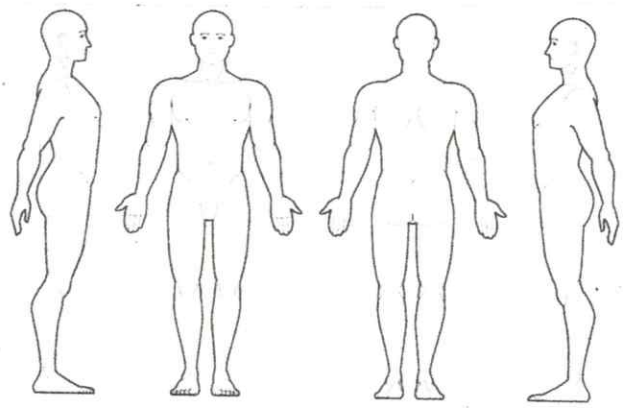
_____

When did this start? __/__/__

PAIN SCALE: None 0 1 2 3 4 5 6 7 8 9 10 Severe .....

Any past history I should know about? What? :

Circle area(s) of problem on image below.. Describe briefly each circled area (example: ache, stiff, radiating, sharp, etc.)



Signature: _____

If this is a return visit.... Was I helpful? Y N . How/How not? :