

WHERE ARE YOU NOW????

Please Complete

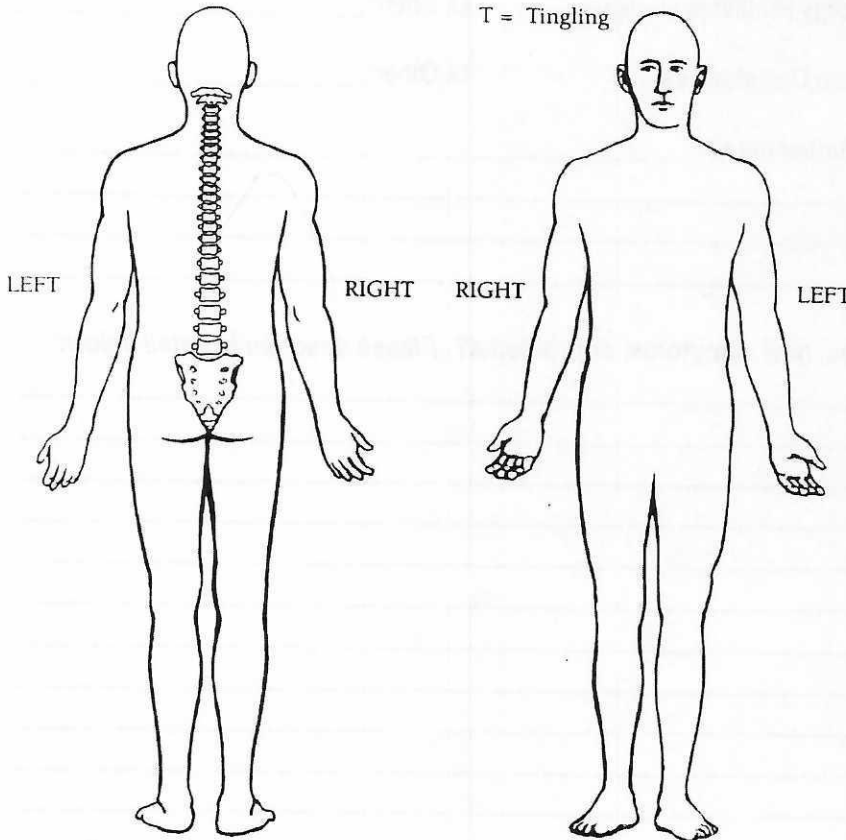
Name: _____ Date: _____

MARK PAIN AREA

- +++ = Burning
- 000 = Stabbing
- = Sharp
- 111 = Constant
- XXX = Other

MARK AREA

- A = Ache
- N = Numbness
- P = Pain
- S = Soreness
- STF = Stiffness
- T = Tingling



Please mark area of pain on the drawing using the code listed above.

SEVERITY OF DISCOMFORT/PAIN

List region of discomfort/pain and circle severity number (1 is low and 10 is high)

For Example:

Neck 1 2 3 4 5 6 7 8 **9** 10 sharp

REGIONS

Headache	1	2	3	4	5	6	7	8	9	10
Neck	1	2	3	4	5	6	7	8	9	10
Shoulders - L R	1	2	3	4	5	6	7	8	9	10
Arms - L R	1	2	3	4	5	6	7	8	9	10
Mid Back	1	2	3	4	5	6	7	8	9	10
Low Back	1	2	3	4	5	6	7	8	9	10
Hips - L R	1	2	3	4	5	6	7	8	9	10
Legs - L R	1	2	3	4	5	6	7	8	9	10
Ankles - L R	1	2	3	4	5	6	7	8	9	10
Feet - L R	1	2	3	4	5	6	7	8	9	10
Mental/ Emotional	1	2	3	4	5	6	7	8	9	10
Stressed Out	1	2	3	4	5	6	7	8	9	10

LIST YOUR FOUR MAJOR SYMPTOMS IN ORDER OF IMPORTANCE:

1. _____
2. _____
3. _____
4. _____

HELPS	POSITION	HURTS	HELPS	POSITION	HURTS	HELPS	POSITION	HURTS
<input type="checkbox"/>	Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	Lying on Side	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>
<input type="checkbox"/>	Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Other: Describe:	<input type="checkbox"/>
<input type="checkbox"/>	Bending Leg	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	_____		
<input type="checkbox"/>	Driving	<input type="checkbox"/>	<input type="checkbox"/>	Stretching	<input type="checkbox"/>	_____		
<input type="checkbox"/>	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	Stretching Leg	<input type="checkbox"/>	_____		
<input type="checkbox"/>	Lying Face Down	<input type="checkbox"/>	<input type="checkbox"/>	Turning Body	<input type="checkbox"/>	_____		
<input type="checkbox"/>	Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	Turning Head	<input type="checkbox"/>	_____		

(Please fill out other side)

(Continued from previous page)

Are there any other Systems involved with your current symptoms? (Please check all boxes which apply)

- Digestion Menstrual Immune System Challenges
- Elimination Pregnancy Colds
- Breathing Menopause Flu
- Circulation / Heart Sexual Dysfunction Other: _____
- Arthritis Energy Problems / Fatigue Other: _____
- Joint Pain Sleep Disturbances Other: _____

(Please feel free to explain any of the above in further detail) _____

Do you currently have any other health issues, new symptoms, or problems? Please describe in detail below:

Any other health issues you would like addressed? (i.e. diet, exercise, weight control, detoxification, relaxation techniques, hormonal balancing, nutritional balancing, etc.)

Thank you for your time and effort in filling out this form. It will be of great help to us in our efforts to provide the best possible health care for you.

Signature: _____