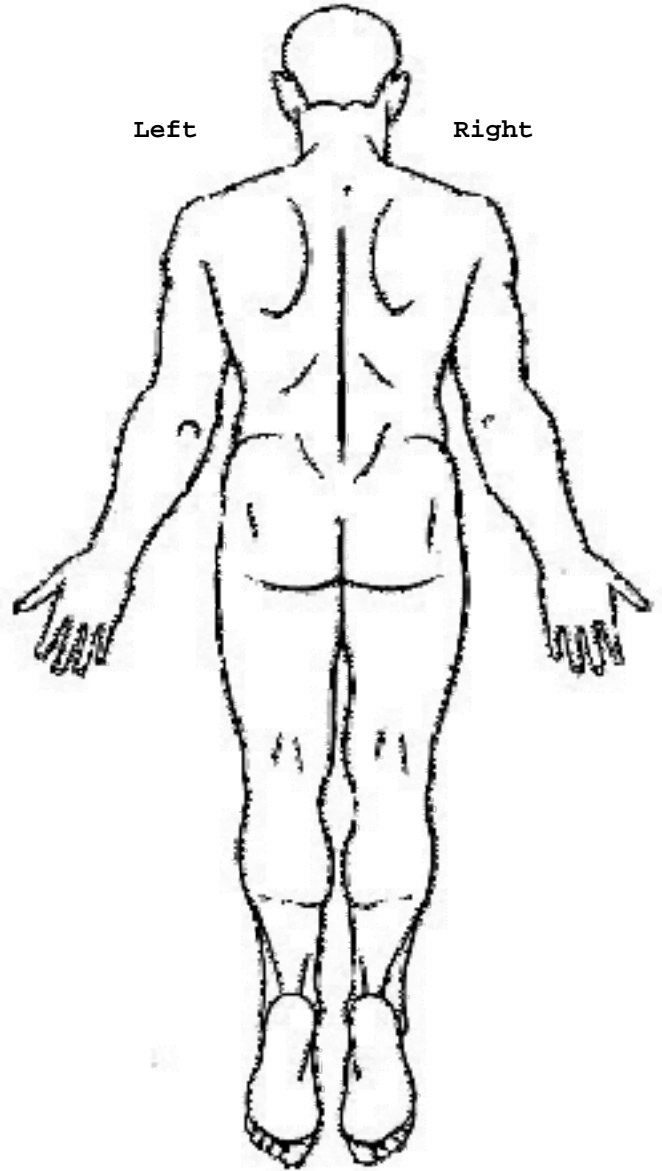
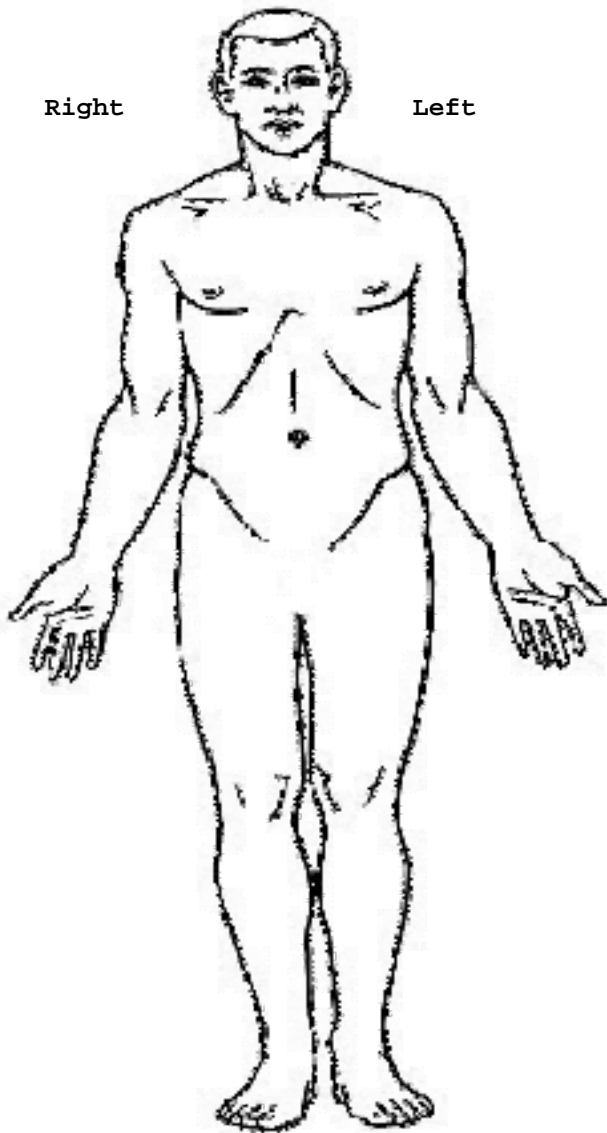


Please mark an "X" on the body part(s) where you have **pain**,
NAME: _____

PATIENT

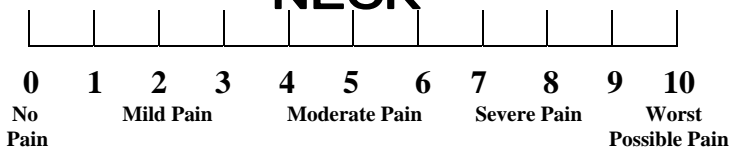
an "0" on the body part(s) where you have **numbness**.

DATE: _____

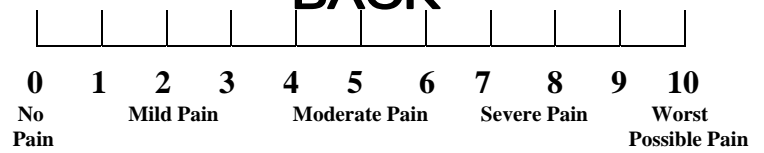


PLEASE CIRCLE THE NUMBERS TO INDICATE YOUR TYPICAL PAIN LEVEL.

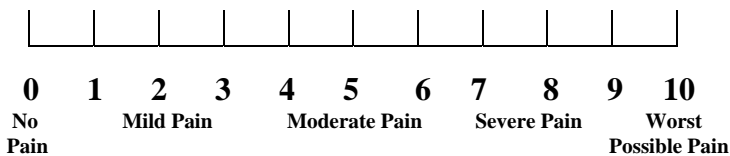
NECK



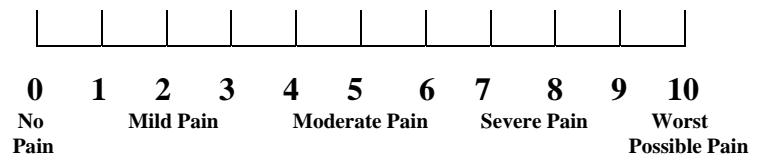
BACK



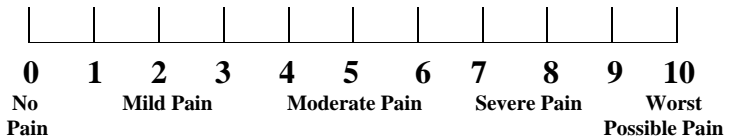
RIGHT ARM



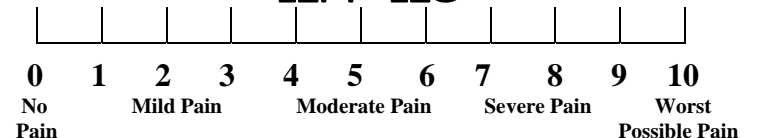
RIGHT LEG



LEFT ARM



LEFT LEG



-OVER-
Review of Systems

In the past month, have you experienced any of the following? Please put a check mark in front of any/all of the following that you have experienced. If you have experienced any of the symptoms, please be sure to notify your family doctor.

HEENT

- Blurred vision
- Dry Eyes
- Hard of hearing
- Nasal Congestion
- Sore Throat
- Cough
- Other: _____

PULMONARY

- Shortness of breath
- Other: _____

ABDOMINAL

- Abdominal Pain
- Other: _____

INTEGUMENTARY

- Moles
- Skin Rash
- Other: _____

NEUROLOGIC

- Tremors
- Other: _____

GASTROINTESTINAL

- Constipation
- Diarrhea
- Other: _____

CARDIOVASCULAR

- Chest pain
- Other: _____

GENERAL

- Fevers
- Chills
- Night sweats
- Stress
- Poor sleep
- Swelling of feet
- Swollen glands
- Problems with blood clots
- Weight Loss
- Weight Gain
- Other: _____

WORK STATUS:

- Full-time
- Part-time
- Not Working
- Regular Duty
- Modified Duty with restrictions

Restrictions: _____

MEDICATIONS: Please list all the medications you are currently taking.

Please Note: This must be completed each time you visit our office, or you may bring a list for us to photocopy. **Do not write "same as last time."**

Medication	Dosage	Times Per Day	Medication	Dosage	Times Per Day