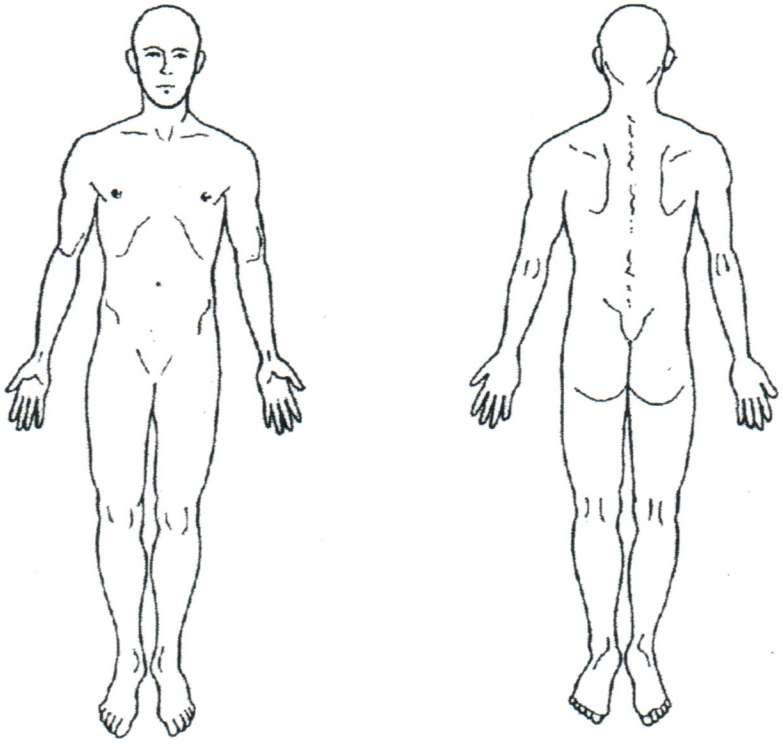
Your name _____ Today's date _____ 200__

SHOW US WHERE YOU HURT

Please read carefully

Draw a circle around the word or words that best describe your symptoms. Circle areas of complaint on the drawing. Connect the two with a line. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

Aching **Burning** **Dull** **Pins & Needles** **Stabbing** **Sharp** **Throbbing**



No pain (0) _____1_____2_____3_____4_____5_____6_____7_____8_____9_____(10) **Severe pain**

Circle the number on the line above corresponding to the level of pain you have today.

Date of Onset _____/_____/_____

In what way is your condition affecting your activities of daily living? _____

_____

_____

_____

If a staff member has written your statements for you, please initial here verifying accuracy. _____

For Use by Dr. Clyde Miller, Sr. Only

	Cervical CMT		Ultrasound - C T L		X-ray		Examination
	Thoracic CMT		Interferential - C T L				
	Lumbar CMT		Diathermy				
	Pelvic CMT		Cyrotherapy				
	Extremity CMT		Muscle Stim				
	TMJ CMT		Electro Therapy - C T L		Manual Traction		Muscle Testing
	TP Manipulation				Intersegmental Traction		Orthotics
	Myofascial Release				Ambulatory Traction		Next. Appt.