Authentic Life chiropractic

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HEALTH CONDITION FORM

Name: _____ Date: _____

Please list the area of your body where you are experiencing pain and circle all that apply:

1. Location: _____ on (Right / Left / Both) side(s). Is the pain (Mild / Moderate / Severe)?
   Describe the pain (Ache / Sharp / Tightness / Burning / Numbness / Tingling / Other:_____)
   How often do you feel the pain (Constant / Frequent / Intermittent / Occasional)
   Is the pain localized or does it radiate down your arm/leg (Local / Radiates / Arm / Leg)
   When did it start? _____ What makes it better? _____
   What makes it worse? _____
   What activities are hard for you to do because of the pain? (Work, Sitting, Standing, Exercising, Lying down, Reaching up, Bending over, Bathing, Housework, Other: _____

Please circle the number on the scale which indicates how much pain you are feeling ***TODAY.***

0 1 2 3 4 5 6 7 8 9 10
NO PAIN WORST PAIN

2. Location: _____ on (Right / Left / Both) side(s). Is the pain (Mild / Moderate / Severe)?
   Describe the pain (Ache / Sharp / Tightness / Burning / Numbness / Tingling / Other:_____)
   How often do you feel the pain (Constant / Frequent / Intermittent / Occasional)
   Is the pain localized or does it radiate down your arm/leg (Local / Radiates / Arm / Leg)
   When did it start? _____ What makes it better? _____
   What makes it worse? _____
   What activities are hard for you to do because of the pain? (Work, Sitting, Standing, Exercising, Lying down, Reaching up, Bending over, Bathing, Housework, Other: _____

Please circle the number on the scale which indicates how much pain you are feeling ***TODAY.***

0 1 2 3 4 5 6 7 8 9 10
NO PAIN WORST PAIN

3. Location: _____ on (Right / Left / Both) side(s). Is the pain (Mild / Moderate / Severe)?
   Describe the pain (Ache / Sharp / Tightness / Burning / Numbness / Tingling / Other:_____)
   How often do you feel the pain (Constant / Frequent / Intermittent / Occasional)
   Is the pain localized or does it radiate down your arm/leg (Local / Radiates / Arm / Leg)
   When did it start? _____ What makes it better? _____
   What makes it worse? _____
   What activities are hard for you to do because of the pain? (Work, Sitting, Standing, Exercising, Lying down, Reaching up, Bending over, Bathing, Housework, Other: _____

Please circle the number on the scale which indicates how much pain you are feeling ***TODAY.***

0 1 2 3 4 5 6 7 8 9 10
NO PAIN WORST PAIN

4. Location: _____ on (Right / Left / Both) side(s). Is the pain (Mild / Moderate / Severe)?
   Describe the pain (Ache / Sharp / Tightness / Burning / Numbness / Tingling / Other:_____)
   How often do you feel the pain (Constant / Frequent / Intermittent / Occasional)
   Is the pain localized or does it radiate down your arm/leg (Local / Radiates / Arm / Leg)
   When did it start? _____ What makes it better? _____
   What makes it worse? _____
   What activities are hard for you to do because of the pain? (Work, Sitting, Standing, Exercising, Lying down, Reaching up, Bending over, Bathing, Housework, Other: _____

Please circle the number on the scale which indicates how much pain you are feeling ***TODAY.***

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NO PAIN WORST PAIN

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HEALTH CONDITION FORM CONT…

Name: _____ Date: _____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-A Pin/Needles-P Burning-B Sharp/stabbing-S Numbness-N Tightness-T