DATE ____________________

PATIENT NAME ____ PHONE ______________

ADDRESS ____________________________________ CITY ________________ ZIP __________

DRAWMAN

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS

KEY: A – ACHE B – BURNING P – PINS
S – STABBING N – NUMBNESS
X – AS DESCRIBED

PLEASE NOTE YOUR PAIN ON A SCALE FROM 0 – 10

RIGHT NOW

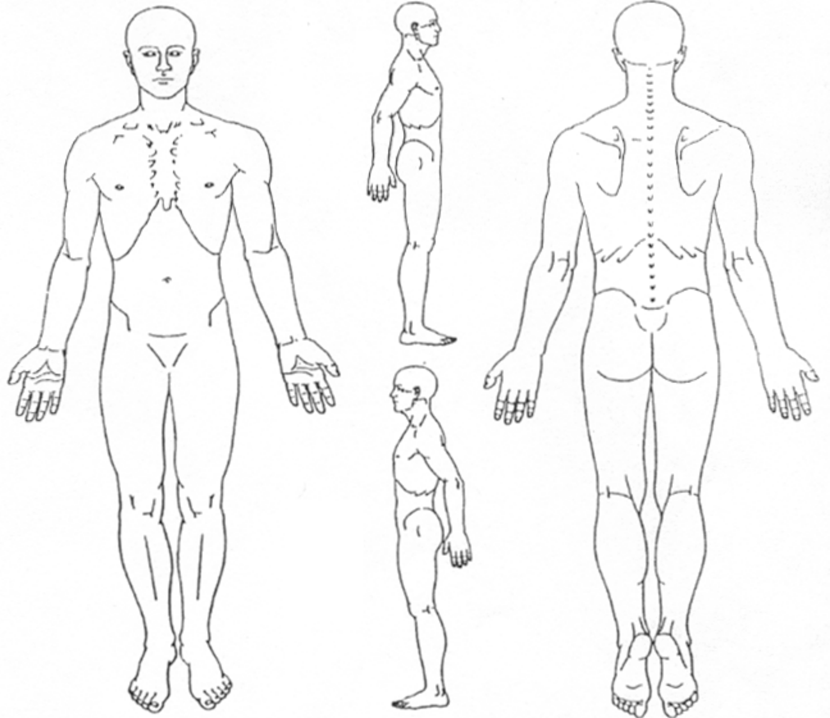
NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

AT WORST

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

AVERAGE

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



DATE OF ONSET ________________ PREVIOUS OCCURRENCE ☐ YES DATE ____________ ☐ NO

☐ IMPROVING ☐ SAME ☐ WORSENING BETTER IN: ☐ AM ☐ PM WORSE IN: ☐ AM ☐ PM

WHAT AGGRAVATES CONDITION ____

____

ANY POSITION THAT RELIEVES SYMPTOMS ____

____

HOW OFTEN DOES IT OCCUR ____

HOW LONG DOES IT LAST ____

WHAT HAVE YOU DONE AT HOME TO HELP ____

____

WAS IT HELPFUL ☐ YES ☐ NO

IS YOUR VISIT DUE TO AN ACCIDENT ☐ YES: ☐ WORK ☐ AUTO ☐ OTHER ______________ ☐ NO