Name: ____________________ Date: ________

My chief complaint is: ____________________

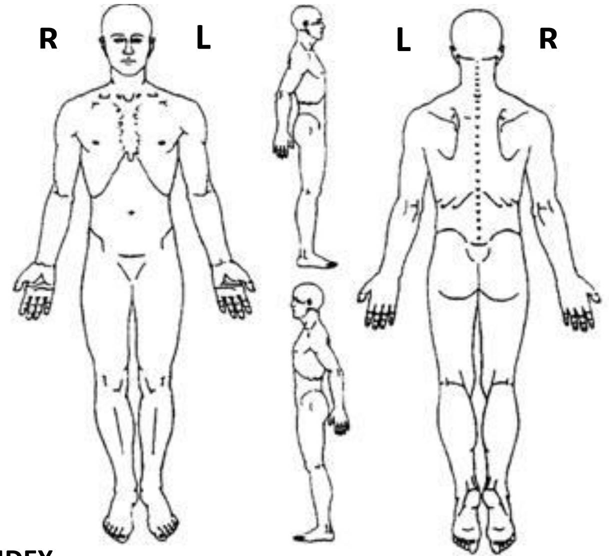
2nd complaint: ____________________

3rd complaint: ____________________

Using the **symbols** below, please draw the location and type of pain on the body outlines:

Ache:	Burning:	Numbness:
MMM M	-- -- -- -- --	⬭ ⬭ ⬭ ⬭ ⬭

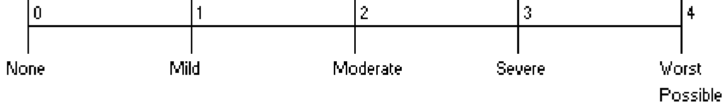
Pins and Needles:	Stabbing:	Other:
ooooooooooooo ooooo	///////// ////	X X X X X X X X



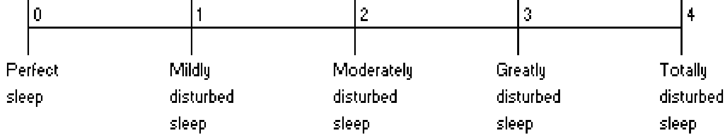
FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage every day activities. For each item below, **please CIRCLE the area which most closely describes your condition right now.**

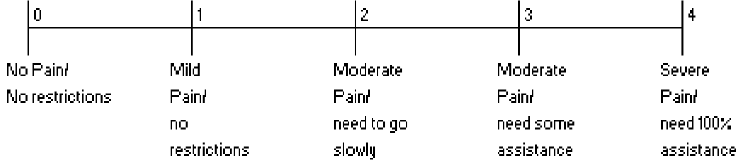
1. Intensity of problem



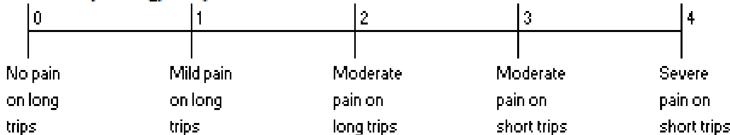
2. Sleeping



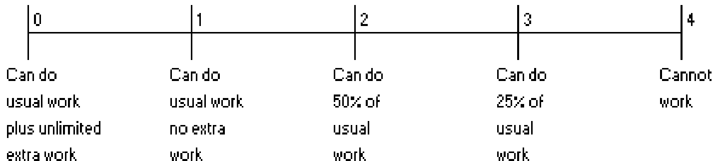
3. Personal Care (washing, dressing, etc.)



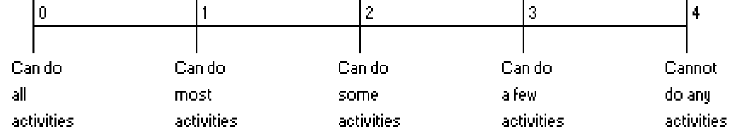
4. Travel (driving, etc.)



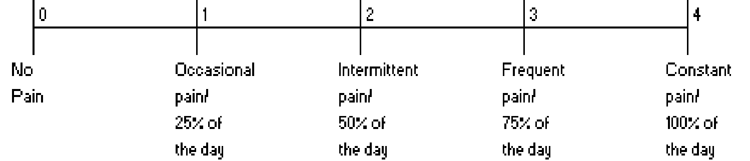
5. Work



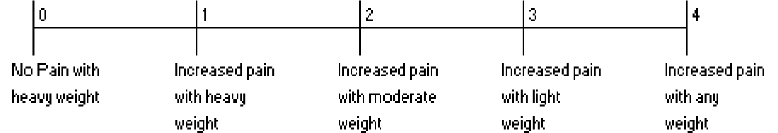
6. Recreation



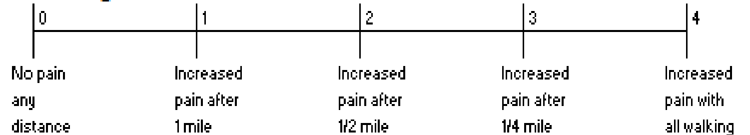
7. Frequency of pain



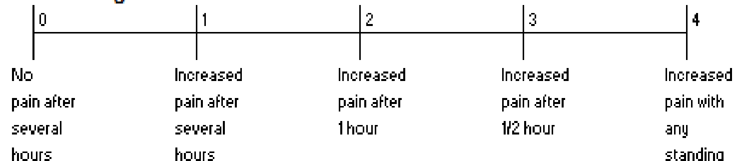
8. Lifting



9. Walking



10. Standing



Patient Signature: ____________________ Date: ________

PERSONAL HEALTH HISTORY

CHECK ALL THAT APPLY							
	AIDS / HIV		Fatigue		Mid Back Pain		TMJ (Jaw)
	Alcoholism		Frequent Colds		Migraines		STDs
	Allergy Shots		Gout		Multiple Sclerosis		Stroke
	Anemia		Headaches		Numbness		Ulcers
	Anorexia / Bulimia		Hearing Loss		Osteoarthritis		Vision Problems
	Arthritis		Heart Attack		Osteoporosis	**Women Only:**	
	Bed Wetting		Heartburn		Pacemaker		Cramps
	Bronchitis		Hepatitis		Pinched Nerve		Hysterectomy
	Chemical Dependency		Herniated Disc		Prostate Problem		Irregular Menses
	Diabetes		High Blood Pressure		Rheumatoid Arthritis		Menopause
	Difficulty Breathing		High Cholesterol		Ringing in Ears		Miscarriage
	Dizziness		Infertility		Sinus Infections		PMS
	Epilepsy		Low Back Pain		Sleeping Problems		Pregnant
	Cancer		Neck Pain		Thyroid Problems		Due Date:_____________

To obtain a better understanding of your current state of health, please answer the following questions:

How long do you believe it took to get where your health is today? ______

How long do you believe it will take you to get better? ______