

Johnstown Chiropractic

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Name: _____

File # _____

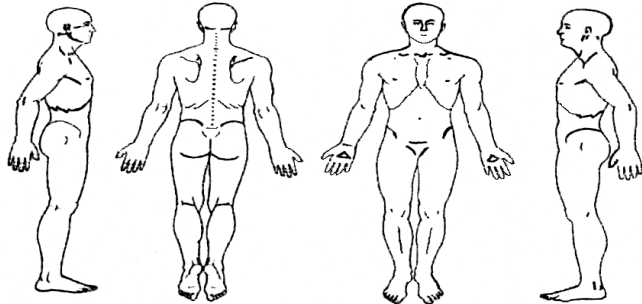
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

- morning -Increase during the day
- afternoon -same all day
- night -decrease during the day



3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition ___ Improved ___ Gotten Worse ___ Stayed the same since it began?

10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ___ No ___ Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ___ No ___ Yes How long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? ___ Good ___ Poor Comments _____

15. Is this condition interfering with ___ Work ___ Sleep ___ Daily Routine ___ Recreation

16. List any other major injuries you have had, other than those mentioned above: _____

17. Any other Musculoskeletal problems? ___ No ___ Yes ...Neurological problems? ___ No ___ Yes

_____ Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____

Date: _____