

Patient Update

Name: _____ Date: _____

After your last visit, how long were your symptoms improved? _____

At the time of this visit are you feeling better worse same compared to how you felt at your last visit?

Please describe _____

Symptoms improve with Rest Activity Hot/Cold Packs Therapeutic Massage Medication

Symptoms worsened by Work Standing/Sitting Lying down Activity/Exercise Other

Since your last visit, have you experienced any of the following?

Headaches: Frequency _____ Duration _____ Intensity _____

Neck pain or stiffness: _____

Shoulder pain or stiffness: _____

Back pain or stiffness: _____

Hip/Pelvic pain or stiffness: _____

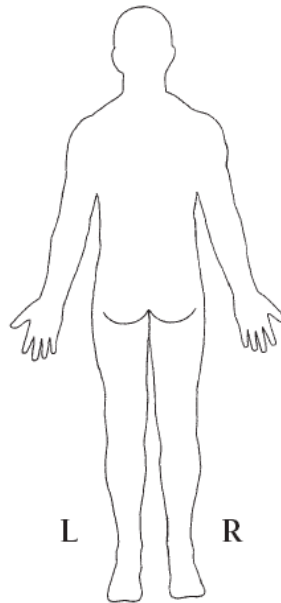
Arm or Leg pain or stiffness: _____

Sleep difficulty: _____

Other symptoms: _____

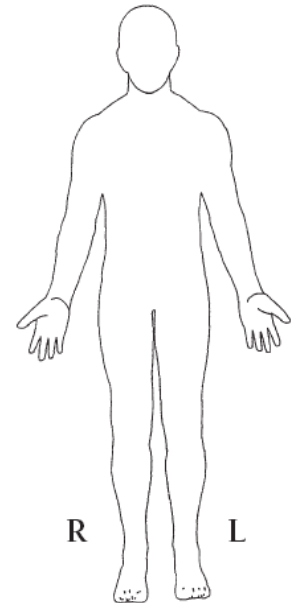
On a scale of 1—10, mark the level of pain you are experiencing today on the figures to the right.

Please mark any areas of numbness/tingling, stabbing pain, spasm, stiffness, loss of mobility or other discomfort, and describe below:



L R

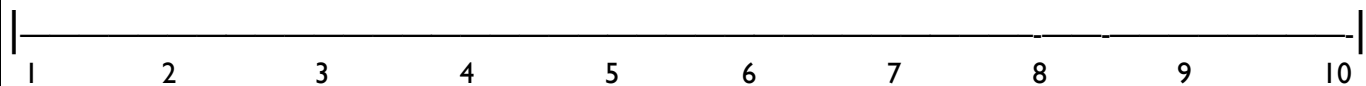
Back



R L

Front

On the scale below, please rate your pain for the past week. Mark an N for pain you have right now. Mark a B for your pain at its best. Mark an A for your average pain this week. Mark a W for your worst pain this week.



Patient signature

Date