

EVALUATION FORM

Demographics:

Height: _____ Weight: _____ Handedness: Right / Left

Reason for today's visit: _____

How and when did the pain/problem start? _____

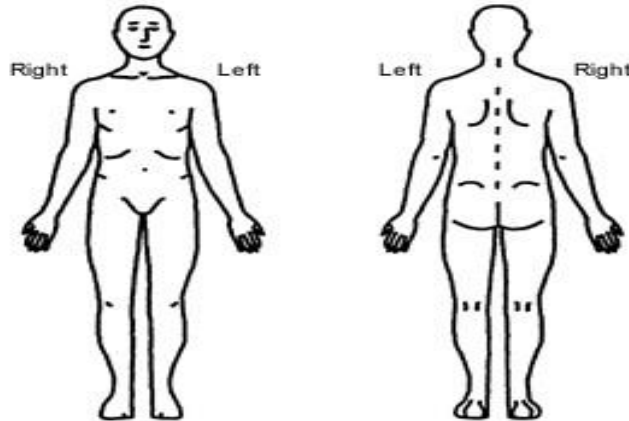
On the diagram below please mark the location of your pain. Use the key to specify what type of pain.

S = Sharp pain

D = Dull pain

N = Numbness

T = Tingling



PAIN:

Using the pain scale below, please rate how your pain is TODAY:



0 1 2 3 4 5 6 7 8 9 10
 No pain Mild Pain Mod Pain Severe Pain Very Severe Worst Possible

Treatment	Was it helpful?	Number of treatments?	Date of most recent?
Physical Therapy			
Acupuncture			
TENS			
Massage			
Psych Therapy			
Chiropractor			
Injections			
Braces			
Exercise			
Surgery			