

Brief Review of Systems (check all that apply)

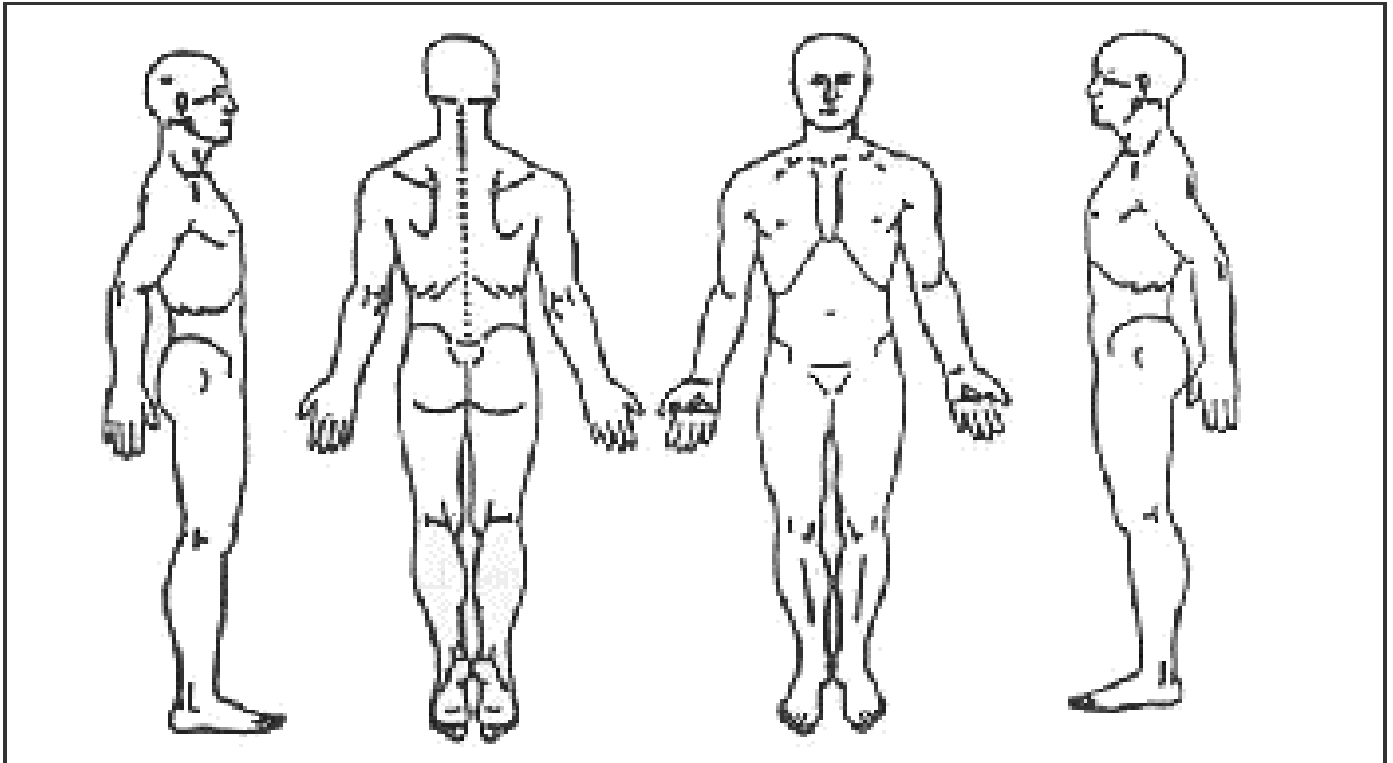
Asthma_____	Headaches_____	Neck pain_____
Shoulder pain _____	Elbow pain_____	Wrist pain_____
Mid back pain _____	Low back pain_____	Hip pain _____
Knee pain_____	Ankle pain_____	Broken Bone_____
Surgeries_____	Heart Disease_____	Chest pain_____
Dizziness_____	Pins and Needles_____	Numbness_____
Arthritis_____	High blood pressure_____	Stroke_____
Heart Disease_____	Diabetes_____	Cancer_____
Heart implants_____	Indicate any joint replacement_____	
Other_____	_____	

Pain Diagram

What does your complaint feel like? (circle all that apply)

Numbness Tingling Ache Cold Hot Burning Throbbing Sharp Itch

On the pain diagram below, please place an X over the area of complaint.



Please rate your complaint on a scale of 0-10. Where 0 is no pain and 10 is the worse pain you have experienced. 0 1 2 3 4 5 6 7 8 9 10

Patient Signature_____ Date_____