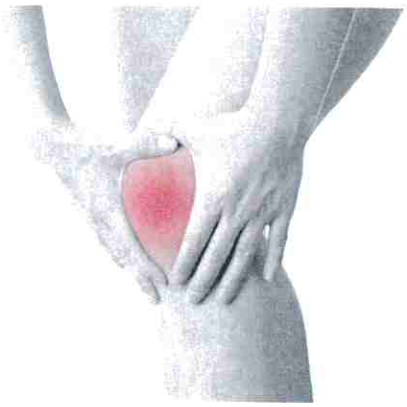
PAIN & HEALTH PROBLEMS SURVEY



Name: _____ Date of Birth: _____ / _____ / _____

Email Address: _____ Best Day & Time to Be Reached: _____

Cell Phone: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ # Hrs of Work Per Week: _____

CHECK OFF WHICH OF THE FOLLOWING OCCURED AT LEAST ONCE IN THE PAST 30 DAYS:

Pain		Decreased Motion		Swelling		Other Problems
___ Knee	R L	___ Knee	R L	___ Knee	R L	___ Overweight
___ Shoulder	R L	___ Shoulder	R L	___ Shoulder	R L	___ Diabetes
___ Hip	R L	___ Hip	R L	___ Hip	R L	___ Digestive Problems
___ Ankle	R L	___ Ankle	R L	___ Ankle	R L	___ Dizziness
___ Elbow	R L	___ Elbow	R L	___ Elbow	R L	___ Fatigue
___ Back		___ Back		___ Back		___ Balance Problems
___ Neck		___ Neck		___ Neck		___ Neuropathy
___ Wrist	R L	___ Wrist	R L	___ Wrist	R L	___ Sleep Problems
___ Hand	R L	___ Hand	R L	___ Hand	R L	_____ Other

Which health problem bothers you the most? _____

On a scale of 1-10, at it's worst, how bad does it get? (1=low, 10=high) _____

How often does it bother you? _____

How long have you had the problem? _____

What could you do before this problem you cannot do now? _____

HOW DOES THE PROBLEM EFFECT YOU?

☐ Moodiness/Irritability	☐ Restricted Activity	☐ Interferes with Exercise/Hobbies
☐ Decreased Energy	☐ Burden to My Family	☐ Reduced Enjoyment of Life

☐ I would like to receive a consultation and evaluation to determine a natural solution to my problems.

Best day of the week to receive an evaluation: _____

Best time of the day for me to receive an evaluation: _____

We will call to confirm your appointment.