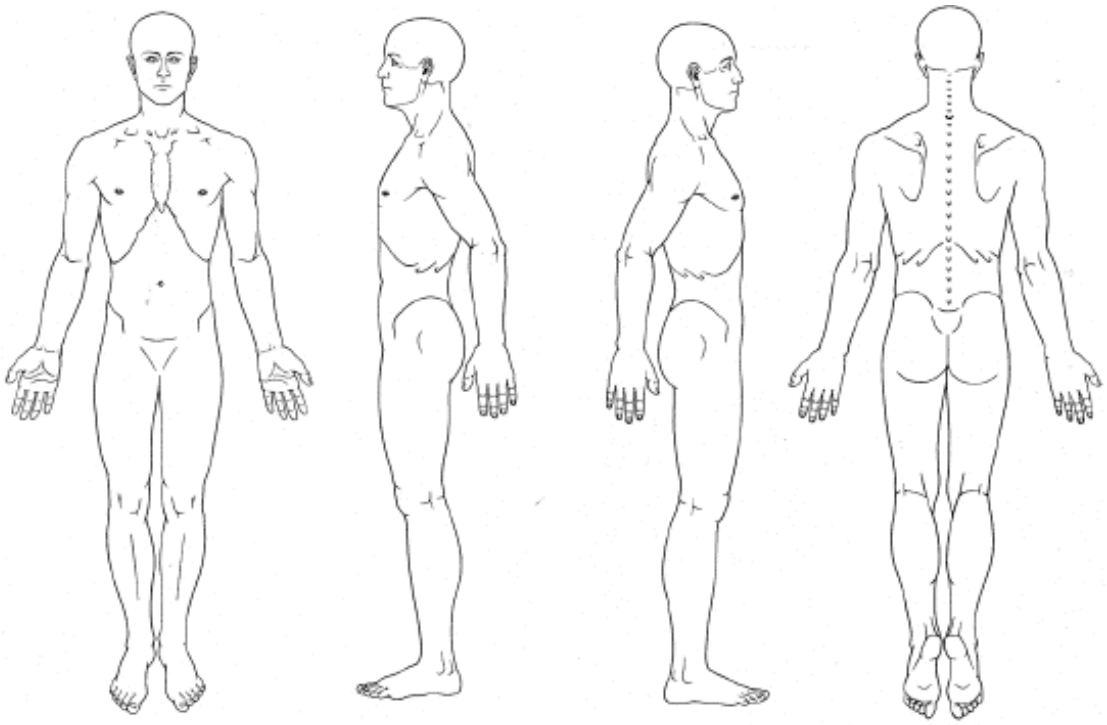
Name: _____ DOB:_____

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described Sensations, RIGHT NOW. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Tingling & Numbness - - - - Sharp oooo Burning xxxx Aching **** Stabbing //// Throbbing^^^^ Dull####



Office Use Only
Ht. ____' _____"
Wt. _____ lbs.
BMI _____
BP _____/_____
Pulse _____ bpm
Resp. _____ cpm
Temp. _____° F

Please place a vertical mark on the line below to indicate the severity of your complaint.

Neck Pain No Pain |——————————————————————| Worse Pain Imaginable

Low Back Pain No Pain |——————————————————————| Worse Pain Imaginable

Other_____ No Pain |——————————————————————| Worse Pain Imaginable

Patient Signature _____ Date _____/_____/_____

Montgomery Chiropractic Center, Inc.
684 Avon Belden Rd.
Avon Lake, OH 44012
Phone: (440) 930-5537
www.MCCenterInc.com