NAME:_____ DATE:_____

PATIENT ID:_____

	Frequency of Pain				Quality of Discomfort											How does Movement Effect it?			Rate from 1-10	What % of the Day is it noticed?	Since your last visit		
	Continuous	Intermittent	Occasional	Numerous	Dullness	Sharpness	Stiffness	Tightness	Achiness	Burning	Stabbing	Throbbing	Mild	Moderate	Severe	Better	Worse	Same	Rate from 1-10	What % of the Day is it noticed?	Better	Worse	Same
Headache																							
Neck																							
Upper Back																							
Mid Back																							
Low Back																							
Right																							
Shoulder																							
Arm																							
Elbow																							
Wrist/Hand																							
Hip																							
Knee																							
Ankle/Foot																							
Left																							
Shoulder																							
Arm																							
Elbow																							
Wrist/Hand																							
Hip																							
Knee																							
Ankle/Foot																							

PATIENT SIGNATURE:_____ DATE_____