



CHIROPRACTIC WELLNESS SOLUTIONS

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Certified in Chiropractic (1976) • Rehabilitation (1998)
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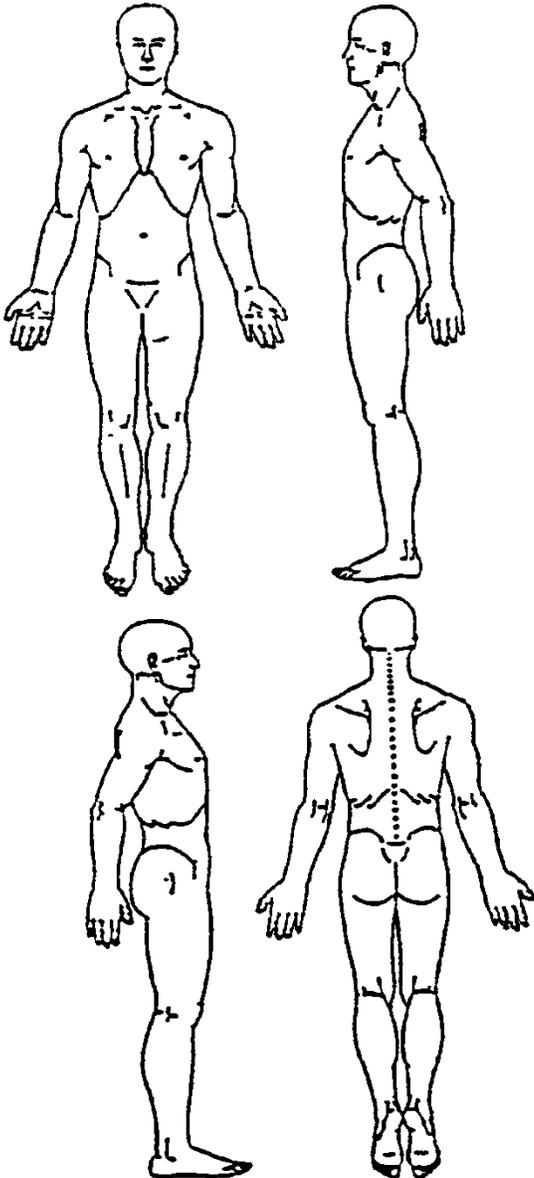
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Patient Name: (Print) _____, _____ Today's Date: ___ / ___ / ___
(Last name) (First Name) Day Month Year

On the body diagram below (left), please draw the area(s) of your discomfort using the symbols below:

DULL ACHE - - - - -	THROBING + + + +	STIFFNESS *****	BURNING # # # #	SHARP /////	STABBING = = =	NUMBNESS V V V V	PINS & NEEDLES X X X X
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Please indicate beside the list of body areas below, the numerical value representing your degree of pain (lowest to highest), where '0' represents no pain to '10' severe pain. Also, circle what side of your body experiences this pain the most.

Body Area	Pain # (0 to 10)	Body Side
Headache		Top, Front, Back, Side
Face / Sinus		L R Both
Ears / Nose		L R Both
Jaw (TMJ)		L R Both
Neck		L R Both
Shoulder		L R Both
Upper Back		L R Both
Chest		L R Both
Rib Cage		L R Both
Arm		L R Both
Elbow		L R Both
Wrist		L R Both
Hand		L R Both
Mid-Back		L R Both
Low-Back		L R Both
Leg		L R Both
Hip		L R Both
Knee		L R Both
Ankle		L R Both
Foot		L R Both
Tailbone		L R Centre