Name _____ **Date**_____

Lake Shore CHIROPRACTIC CENTER
A Chiropractic Rehabilitation Facility

Please describe your MAJOR complaint/Why are you here?: Work Injury Yes No

_____

_____

_____

When did your problem begin? _____ **Previous History of this?** Yes No When?_____

How did it begin? (If Workers' Compensation, you must state what caused your injury/re-injury and date it occurred)

_____

_____

_____

The pain □ is constant □ comes and goes. If it comes and goes, how often does the pain exist?

_____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation □Other_____

Activities or movements that are painful to perform:

□Sitting □Standing □Walking □Bending □Lying Down □None □Other_____

What makes it better? _____

Have you seen another healthcare practitioner for the pain/condition? Yes No

If yes, who? _____

On the diagram below indicate the type of symptoms you are experiencing right now. Use corresponding symbols.

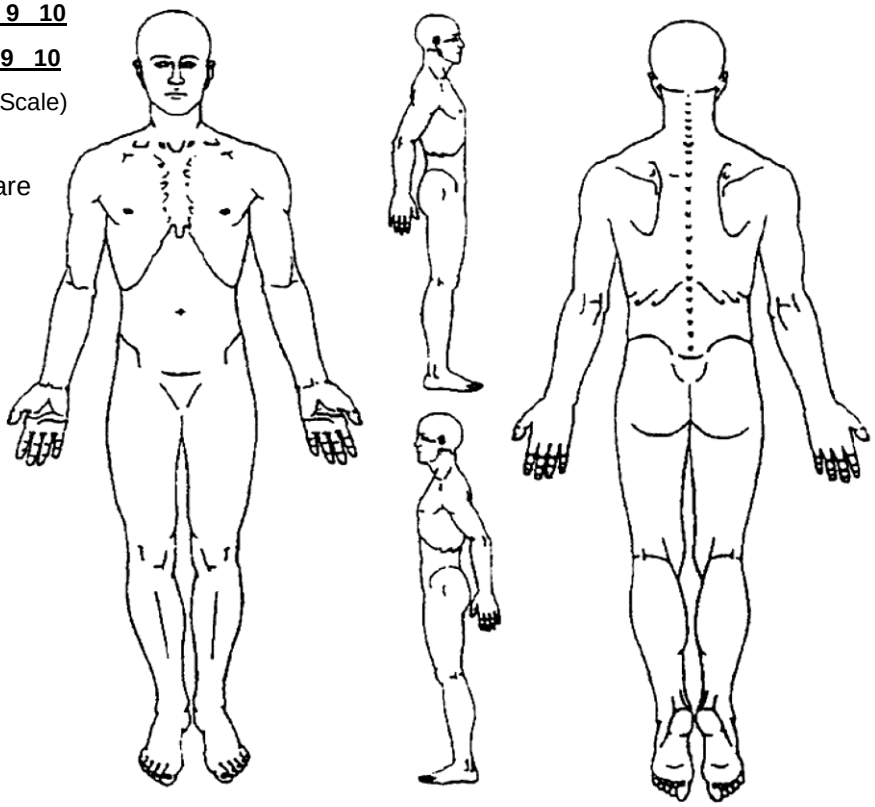
Pain Diagram and Rating

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

- **Current pain:___/10** **0 1 2 3 4 5 6 7 8 9 10**
- **Average pain:___/10** **0 1 2 3 4 5 6 7 8 9 10**

(Visual Analog Pain Severity Scale)

Please mark on the diagram the location of the pain.



Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

☐ Aching **A**
☐ Burning **B**
☐ Dull **D**
☐ Numb **N**
☐ Sharp **S**
☐ Other, describe it: _____

☐ Shooting
☐ Stabbing
☐ Stiffness
☐ Throbbing
☐ Tingling

Comments:

Patient's Signature _____ ____ **Date** _____