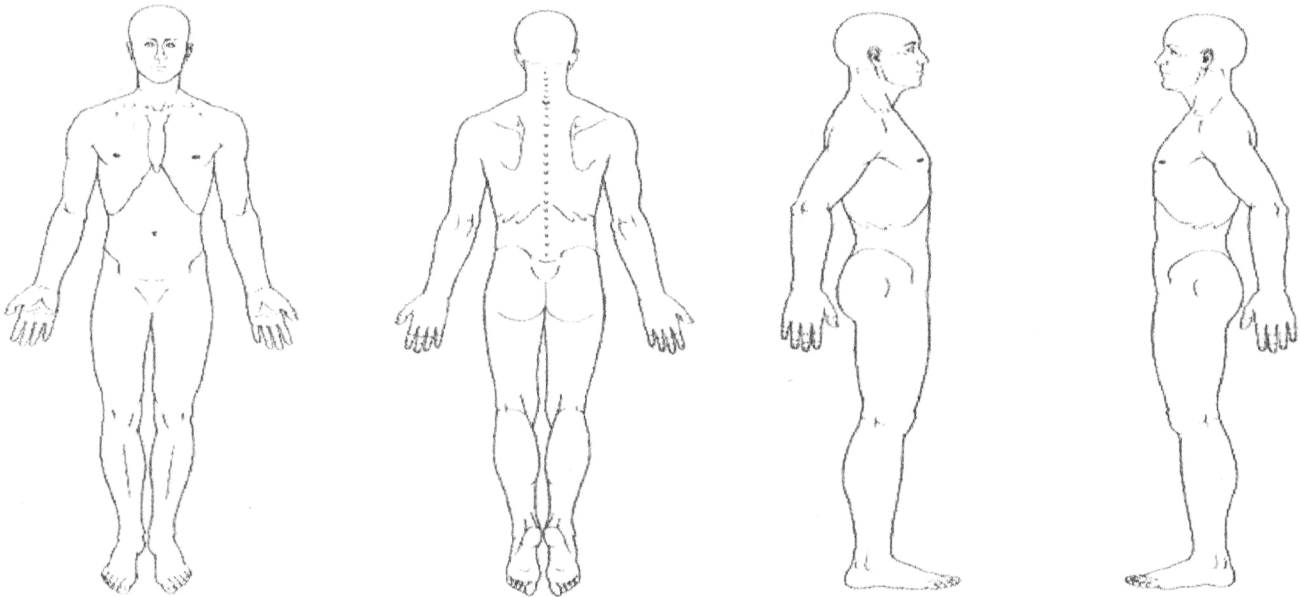




Full Body & Pain History

Date: _____ Date of Birth: _____
 Name: _____ Street: _____
 City: _____ Province: _____ Postal Code: _____
 Tel. (Res.) _____ Tel (Bus.) _____ Email: _____

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
Mild: Annoyance Moderate: Some Limitations Severe: Pain Killers Needed

Describe your symptoms: _____

How and when did this start? _____

Were you examined for this complaint? _____ Date and Results: _____

What increases your symptoms? _____