Brusveen Chiropractic Clinic & Therapy, PLC

Pain Chart

IN CASE OF ACCIDENT, INJURY, OR SUDDEN CHANGE IN YOUR CONDITION

Please give us the information listed below. Be sure to tell us what happened, where, when, and how the problem occurred. If you were hospitalized or received treatment elsewhere, please give details.

Purpose of This Appointment (Problem)

_____

_____

_____

The Major Complaint came on

☐ Gradually ☐ Suddenly

Is This a Result of a Fall, Accident, Injury (Please Describe):

_____

_____

_____

_____

How does this pain affect your daily life?

_____

_____

_____

_____

Signature: _____

Address: _____

Date Of Birth: _____ **Date of Onset:** _____

Print Name_____**Today's Date**_____

Please mark area(s) of injury or discomfort as shown below in the example.

PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Numbness - - - - -

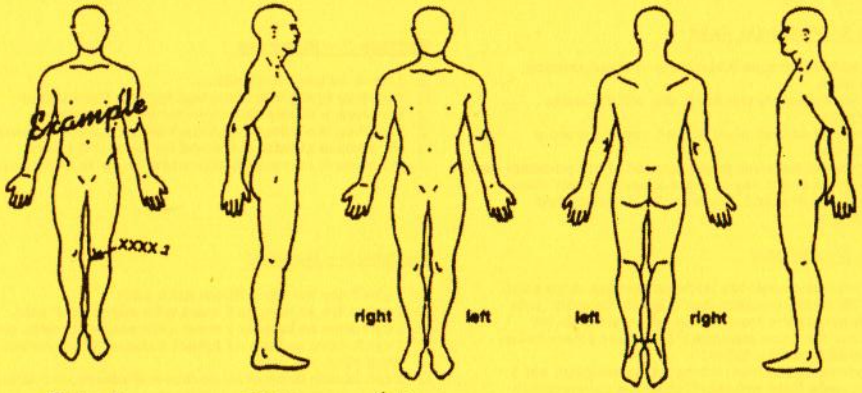
Pins & Needles o o o o o

Burning ^ ^ ^ ^ ^

Aching x x x x x

Stabbing • • • • •

Spasm o o o o o



Example Right Front Back Left

Height _____ **Weight** _____

Balance/Weight Distribution _____ **Right/Left**

Reflexes Right _____ **Left** _____

Temposcope _____

Muscle Spasm _____ **Fixation** _____

Derefield Sign _____ **Sacral Check** _____

Other _____

Tenderness _____

ROM-C _____ **L** _____

Goal SYMPTOM REDUCTION - INCREASE MOBILITY
DECREASE SPASM - BALANCE SPINE - IMPROVE STRENGTH

Other: _____

_____

_____

Treatment Plan _____