CHIROPRACTIC CHOICE, LTD.

Chiropractic Choice
Patient Pain Form

Name: _____

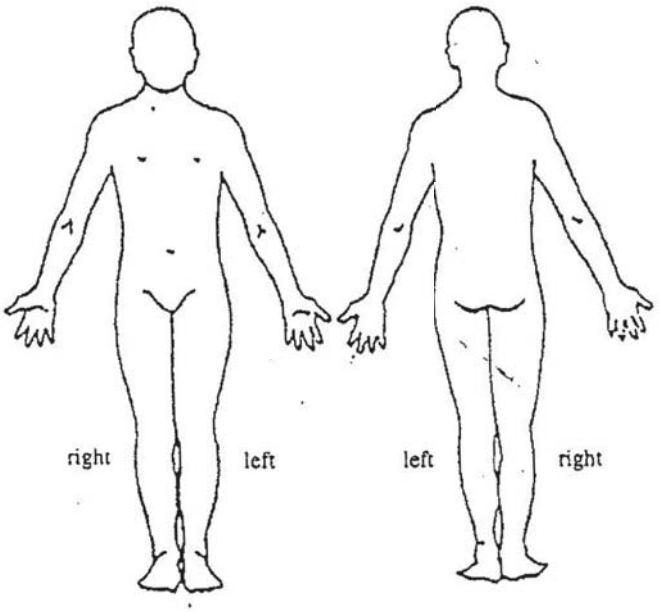
Date: _____

Claim No: _____

DOB _____

Using the symbols listed below, mark on the two drawings below which areas on your body where you feel the described sensations:

Numbness	= = =
Dull Ache	o o o
Hot Burning	x x x
Sharp Stabbing	///
Pins and Needles	+ + +
Other_____	
_____	



Signature: _____ Date: _____

Physician Comments:

Pain Scale:

Please rate the severity of the pain you have felt, in general, over the past few days by checking one box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain