WELCOME TO BROAD STREET CHIROPRACTIC

We thank you for choosing **Broad Street Chiropractic** for your health care needs. We offer state of the art chiropractic care with many other complimentary therapies.

It is important that we know how you heard about our office. Please take a moment and indicate how you heard about our office by putting a check mark in the appropriate box. If more than one choice applies please put a check mark by all that apply. Thank you.

☐ **Referred by**: Please indicate who you were referred by.

☐ ***Existing Patient***: Please write their full name so we may thank them for referring you. _____

☐ ***Doctor, Chiropractor or Health Care Practitioner***: Please write their full name so we may thank them for referring you. _____

☐ ***Attorney***: Please write their full name so we may thank them for referring you. _____

☐ **Managed Care Plan**: Broad Street Chiropractic, or it's doctors, are listed on your managed care plan.

☐ **Yellow Pages**: Please indicate which phone book you were using:

☐ *Durham Verizon*; ☐ *Durham/Chapel Hill Talking Phone Book*, ☐ *Bellsouth-The Real Yellow Pages*

☐ **Internet**: Please indicate which website you were using:

☐ *Google*, ☐ *Verizon Superpages*, ☐ *Yahoo!*, ☐ *City Search*, or ☐ other _____

☐ **Sign**: You saw our sign on the front of the building.

☐ **Publication**: Please write which publication you saw our ad in:

_____

☐ **Other**: Please write how you heard of us if it was not listed above:

_____

Your signature _____ **& Date** _____

CHIROPRACTIC TREATMENT AND ITS RISKS

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing and possibly X-rays. Once your condition has been diagnosed, usually the primary method of treatment is spinal manipulation, also know as spinal adjustment. An adjustment is a quick, precise movement of the spine over a very short distance. Adjustments are usually performed by hand but may be performed by hand guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, deep muscle/ligament massage, cervical or lumbar traction, intersegmental traction (rollerbed), hot and cold packs, dry water massage (hydrobed), exercise/stretches, applied kinesiology, acupressure, acupuncture and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term soreness. More serious side effects can include bone fractures (due to advanced osteoporosis or bone pathology), muscle strain or ligament sprain (inflammation of soft tissue including muscle, tendon, ligament ,disc) , injury to nerves or spinal cord and joint dislocation. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million.

As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns from hot / cold therapy or ultrasound. Occasionally acupuncture may cause mild bruising. Care needs to be taken to insert needles shallow in areas that could be potentially injured to deeper needling. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:
Self administered, over-the-counter analgesics;
Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
Surgery;
Remaining untreated.

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Not receiving chiropractic care and remaining untreated carries its own risk and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

Unusual Risks

If your pre-treatment examination reveals any health issues that would make some forms of chiropractic treatment inadvisable or contra-indicated , Dr. Washington will explain the risks to you and answer any questions you may have.

Patient initials:_____

CONSENT TO CHIROPRACTIC TREATMENT

Dear patient,

Recent guidelines by the North Carolina Board of Chiropractic Examiners require your chiropractic physician to formally explain the treatment being recommended , to inform you of the unusual risks associated with treatment, to explain other treatment options and to answer any questions you may have regarding treatment. You may have been given reading material pertaining to these topics, but your doctor will also discuss them with you in person. Please do not sign this form until you are satisfied that you have received sufficient information to enable you to give your informed consent to treatment.

Note: if the patient is a minor or legally incompetent adult, consent should be given by the patient's parent or legal guardian.

The recommended chiropractic treatment plan has been explained to me, along with any associated risk with chiropractic treatment and other treatment options. I have discussed this with Dr. Washington and my questions have been answered to my satisfaction. No guarantees have been made to me regarding treatment outcomes. I have weighed the risks involved and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to chiropractic treatment.

[If the patient is a competent adult, complete this section.]

Patient name (please print):_____

Patient signature:_____

[If the patient is a minor or legally incompetent adult, complete this section.]

Patient name (please print):_____
Patient age:_____ Date of birth:_____

Person authorized to sign for patient (please print):_____

Relationship to patient: _____

Signature of authorized person:_____ Date :_____

BROAD STREET CHIROPRACTIC

Broad Street Chiropractic is required by law and in compliance with HIPAA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

We may disclose health care information to other healthcare professionals within our practice for the purpose of treatment and healthcare. It is our policy to provide another healthcare provider for your treatment during our absence.

We may disclose your health information to your insurance company for the purpose of payment. As a courtesy, we will submit an itemized statement to your insurance company for the purpose of payment for services rendered. These itemized statements include diagnosis, date of injury or condition, codes describing services rendered and charges.

Health information for patients treated under Worker's Compensation may be disclosed as necessary to comply with State Worker's Compensation Laws.

We may disclose health information to another healthcare provided in response to your referral to or from our office.

We may contact you by mail to provide appointment reminders or information about treatment, alternate treatment or other health benefits, birthday cards, holiday cards, periodic announcements and services that may be of interest to you.

In emergencies, we may disclose your health information to notify or assist in notifying a family member or other individual responsible for your care.

As required by law, we may release health information to public health authorities for purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, domestic violence and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding, law enforcement official, complying with a court order or subpoena or other law enforcement purposes.

As a courtesy, we may call your home or leave a message, stating your next appointment date and time or missed appointments. No personal health information will be disclosed.

You have the right to request restrictions on certain uses and disclosures of your health information. If you have such a request, please notify Broad Street Chiropractic immediately with the restrictions.

You have the right to inspect and receive a copy of your health information. Further, you have a right to request that Broad Street Chiropractic amend your health information but they are not required to agree to amend it. If your request is denied, you will be given an explanation of denial reasons and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your health information made by Broad Street Chiropractic.

Broad Street Chiropractic is required by law to maintain the privacy of your health information. If you have any questions regarding this notice, you may contact the Privacy Officer by calling (919) 286-9430. If you need to make an appointment with the Privacy Officer you may do so by telephone or in person. If you are not satisfied with the way your complaint is handled, you may request the address to file a formal complaint.

We must disclose your health information to DHHS as necessary for them to determine our compliance with HIPAA standards.

Broad Street Chiropractic retains the rights to add, remove or alter this agreement as deemed necessary. Any such changes will be posted in the physical premises of Broad Street Chiropractic and shall be retroactively effective to the date of original signature.

I have read the Privacy Notice and understand my rights contained in the notice.

I provide Broad Street Chiropractic with my authorization and consent to use my protected Health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (printed)

_____ _____
Patient's Signature Date

_____ _____
Authorized Office Signature Date

I authorize release of any medical information or other information necessary to process any claim.

_____ _____
Patient/Authorized Person Date

Further, I authorize payment of medical benefits for services rendered be made payable to Edward H. Washington, Jr. DC / Broad Street Chiropractic.

_____ _____
Patient/Authorized Person Date

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

_____

_____

_____

Doctor

Dr. Edward H. Washington, Jr.

P.O. Box 2172

Durham, NC 27702

RE: Patient records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on_____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated:_____ Patient's signature:_____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated:_____ Authorized signature:_____

NOTICE: Please date, sign, and return one copy to doctor's office at once.
Keep one copy for your records.
Reply envelope attached.

Personal Injury

Personal Information:

First Name:	Last Name:	Middle Initial:
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Cell Phone:
Email (optional):	Social Security No[redacted]	
Date of Birth:	Age:	Height:	Weight:
Dominant Hand: ☐Right ☐Left ☐Both		
Occupation:	Employer:	Employer's Address:

Have you had to miss work due to the injury/onset? **Yes☐ ☐No**

If **Yes**, what dates? _____

Have you been contacted by an ***Insurance Adjuster*** regarding your claim?: **Yes☐ ☐No**

If **Yes**:
What is the name of your Insurance *Adjuster*? _____ , and Company _____

What is their Address? _____ , Phone # _____

Fax # _____

What is your Claim #? _____

Have you retained an ***Attorney*** to represent you in your Personal Injury? **Yes☐ ☐No**

If **Yes**, who is your *Attorney*? _____

What is their Address? _____ , Phone # _____

Fax # _____

If you have an attorney will they be submitting your Med-Pay claim or would you like us to submit this for you?

In the event of an Emergency, whom should we notify?	Relation To Patient	Daytime Phone

Please provide the receptionist with your Driver's License so it can be photo copied.

Please Sign Name On Each Page_____ **& Date**_____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type
❑Car ❑Station Wagon
❑Van ❑Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle
❑Driver ❑Front Passenger
❑Left Rear Passenger
❑Right Rear Passenger
Other_____

3. What was your vehicle doing at time of accident?
❑Stopped at intersection ❑Stopped in traffic ❑Stopped light
❑Making a right turn ❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down ❑Accelerating
Other_____

4. Time/Speed/Damage
Date of Accident_____
Time of accident_____AM or PM
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑Mild ❑Moderate ❑Totaled

5. Details of Accident
Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who/what?
❑You hit other vehicle
❑Other vehicle hit you
You hit...(object)_____

6. Road conditions
Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and dry

Point of impact
❑Head-On ❑Left Front ❑Right Front
❑Rear-End ❑Left Rear ❑Right Rear

7. Body Position, etc.

- Did you see the accident coming: **Yes❑ ❑No**
- Were you braced for the impact? **Yes❑ ❑No**

- Did you have a seat belt on? **Yes❑ ❑No**
- Was your shoulder harness on? **Yes❑ ❑No**

- Did driver side airbag deploy? **Yes❑ ❑No**
- Did passenger side airbag deploy? **Yes❑ ❑No**
- Did the side bags deploy? **Yes❑ ❑No**

- Does your vehicle have headrests? **Yes❑ ❑No**
- What was the position of your headrest at time of the impact?
  ❑Even with top of head ❑Even with bottom of head ❑Middle neck

- What was the direction of your head at the time of impact?
  ❑Facing straight forward ❑Turned to the right ❑Turned to the left

8. Additional accident information

Please write a description of the accident below if there are any other details that were not covered above.

Please Sign Name On Each Page_____ **& Date**_____

9. During the accident:

- Did your body strike anything inside of your vehicle? **Yes❑ ❑No**
  If **Yes**, describe: _____
- Did you experience being dazed or disoriented immediately after the accident? **Yes❑ ❑No**
- Did you lose consciousness during the injury? **Yes❑ ❑No** If yes, for how long? _____
- What is **your** vehicle's estimated damage? _____
- Damage to **their** vehicle: **❑Mild ❑Moderate ❑Totaled**
- Did police show up at the scene? **Yes❑ ❑No**
- Was an accident report filled out? **Yes❑ ❑No**

10. After the accident:

Check off your symptoms immediately after and a few days following the accident:

❑Headache	❑Dizziness	❑Mid back pain	❑Cold hands
❑Neck pain	❑Nausea	❑Low back pain	❑Cold feet
❑Neck stiffness	❑Confusion	❑Nervousness	❑Diarrhea
❑Fainting	❑Fatigue	❑Loss of taste	❑Depression
❑Ringing in ears	❑Tension	❑Toe numbness	❑Anxious
❑Loss of smell	❑Irritability	❑Constipation	❑Chest Pain
❑Pain behind eyes	❑Shortness of breath	❑Sleeping problem	

Others:_____

11. Emergency Room?

- **Where did you go immediately following the accident?** ❑Home❑Work ❑Hospital ER ❑Private Doctor
- **How did you get there?** ❑Self ❑Somebody else ❑Ambulance ❑Police
- **If you did not go to a hospital immediately after the accident, did you go within a few days? Yes❑❑No**
  If YES, what date did you go? ____/____/____

- **What is the name and city of the hospital if you went to one?** _____

- **X-rays done? Yes❑❑No** Body parts X-rayed?_____ The X-rays revealed: _____
- **Lab work? Yes❑❑No** What lab work?_____
- **Treatments:** ❑Cervical Collar ❑Ice **Other:**_____
  Medications: _____
  Follow-up instructions: _____

12. Treatment History:

Fill in any other doctor(s) seen regarding the accident prior to your first visit to this office.

1. Dr. _____	First visit date: ____/____/____
Specialty:_____	X-rays done? **Yes❑❑No**
Types of treatments received:_____	
How many treatments received? _____	Currently treating? **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No**	Last visit date: ____/____/____

2. Dr. _____	First visit date: ____/____/____
Specialty:_____	X-rays done? **Yes❑❑No**
Types of treatments received:_____	
How many treatments received? _____	Currently treating? **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No**	Last visit date: ____/____/____

Please Sign Name On Each Page_____ **& Date**_____

Use the following 1 to 5 scale to describe the difficulties below *(Only fill in AREAS AFFECTED)*:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication (Only fill in areas affected)
Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____
Using a keyboard____

Difficulties with the Senses (Only fill in areas affected)
Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions (Only fill in areas affected)
Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function (Only fill in areas affected)
Being able to have normal restful nights sleep___ Being able to participate in desired sexual activity___

Please write in below any other daily activities you are currently having difficulties with due to your accident:

Prior Symptom History

Prior Similar Symptoms
- ☐I have NOT had prior symptoms similar to my current complaints.
- ☐My current complaints DID exist before, but had not been bothering me.
- ☐My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred:
____☐months ago / ☐years ago; **OR on** Date:_____/_____/_____

Has your History Contributed to your Current Symptoms?
- ☐My history HAS contributed to my current symptoms.
- ☐My history HAS NOT contributed to my current symptoms.
- ☐I 'm NOT SURE if my history has contributed to my current symptoms.

Please write in below any other symptoms or problems that you had BEFORE the accident that were not covered above:

Thank you for your time and thoroughness in filling out these forms. It will assist us in meeting your health care needs.

Please Sign Name On Each Page_____ **& Date**_____

Description of Symptoms

Describe only your **WORST** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

A) FIRST Current Symptom:
(Please check off the boxes in the sections below to describe your one **WORST** symptom.)

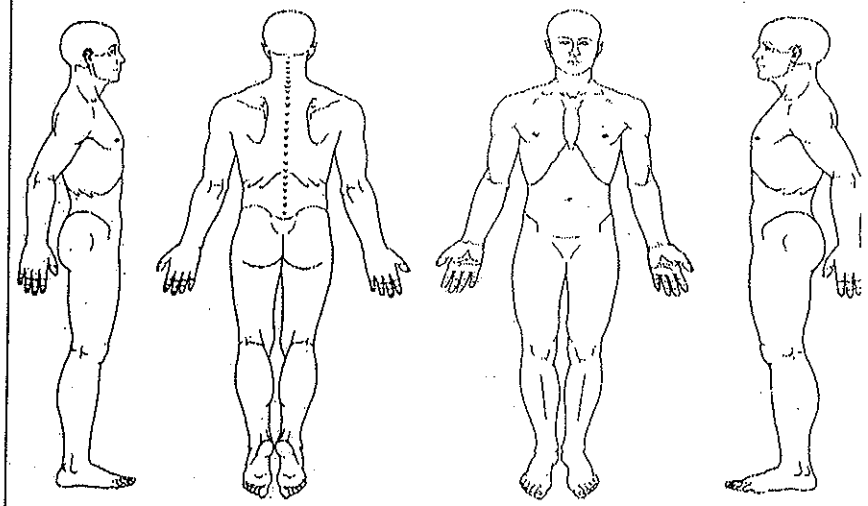
1. *Check only ONE body location below*

	Left	Right	Both
Choose one:			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑
❑Headaches	L❑	R❑	B❑

❑Front of Head ❑Top of Head ❑Back of Head

Other locations: _____

Indicate on the drawing below the location of your WORST complaint only



2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling
❑Spasm ❑Stinging ❑Shooting ❑Pounding
❑Cramping ❑Constricting

Other types of pain: _____, _____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation: _____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
_____	❑	❑	❑

Please Sign Name On Each Page _____ **& Date** _____

Description of Symptoms

Describe only your **SECOND** symptom, or complaint, on this page. Additional complaints can be entered on the following pages.

B) SECOND Current Symptom:
(Please check off the boxes in the sections below to describe your **SECOND** symptom.)

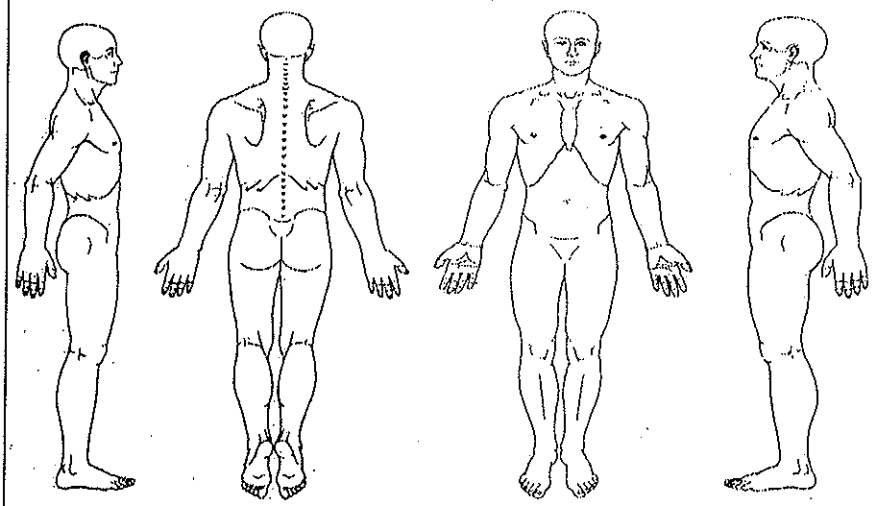
1. *Check only ONE body location below*

	Left	Right	Both
Choose one:			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑
❑Headaches	L❑	R❑	B❑

❑Front of Head ❑Top of Head ❑Back of Head

Other locations:_____

Indicate on the drawing below the location of your SECOND complaint only



|----------|

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling
❑Spasm ❑Stinging ❑Shooting ❑Pounding
❑Cramping ❑Constricting

Other types of pain: _____, _____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
_____	❑	❑	❑

Please Sign Name On Each Page_____ **& Date**_____

Description of Symptoms

Describe only your **THIRD** symptom, or complaint, on this page. Additional complaints can be entered on the following pages.

C) THIRD Current Symptom:
(Please check off the boxes in the sections below to describe your **THIRD** symptom.)

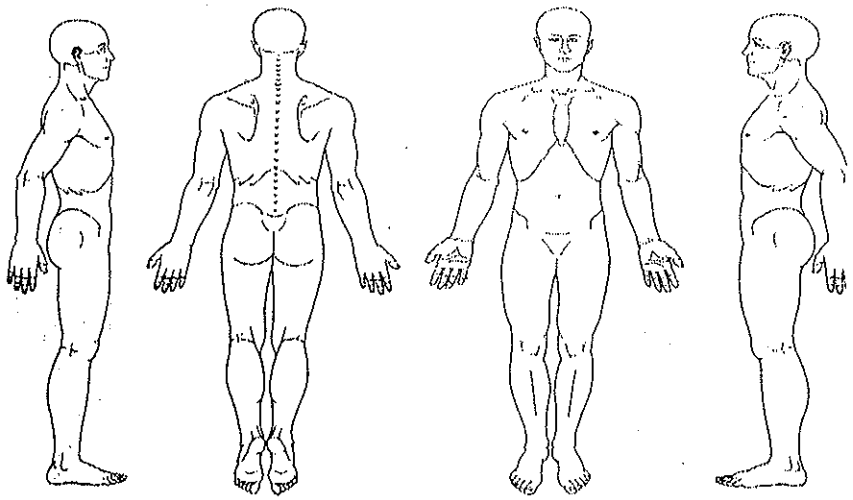
1. *Check only ONE body location below*

	Left	Right	Both
Choose one:			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑
❑Headaches	L❑	R❑	B❑

❑Front of Head ❑Top of Head ❑Back of Head

Other locations:_____

Indicate on the drawing below the location of your THIRD complaint only



2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling
❑Spasm ❑Stinging ❑Shooting ❑Pounding
❑Cramping ❑Constricting

Other types of pain: _____, _____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activities)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forward	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
_____	❑	❑	❑

Please Sign Name On Each Page_____ **& Date**_____