VALENTE CHIROPRACTIC

# Patient Current Condition and Pain Form

**Name:** ______________________________________ **Date:** ________________________

**Complaint/Pain Location(s)** (example: neck, shoulders, upper back, mid-back, low-back, hips, extremities):

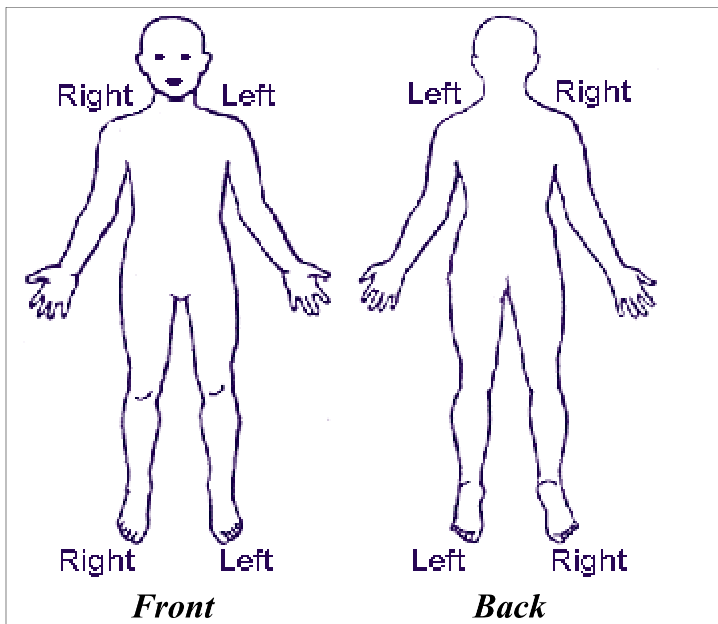
__________________________________________________________________________

**Usual Pain Intensity**

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

**Today's Pain Intensity**

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain




**On the image please indicate where you are experiencing your symptoms.**

**Date of Injury/Onset:**___________________________

How would you describe the character of your condition/pain? (please check all that apply)

☐Sharp ☐Dull ☐Tingling ☐Numb
☐Aching ☐Shooting ☐Radiating ☐Burning
☐Throbbing ☐Cramping ☐Stiffness ☐Swelling
☐Other ________________

**How often do you experience your symptoms?**

☐ Constantly (76%-100% of the time)
☐ Frequently (51%-75% of the time)
☐ Occasionally (26%-50% of the time)
☐ Intermittently (0%-25% of the time)

**When do you experience your symptoms?**
Ex: every day, most days, some days, a few times a year

__________________________________________

Does your condition interfere with your.... (please check any that apply)
☐ Sleep ☐ Work ☐ Daily routine ☐ Recreational activities

| | Comfortable | Uncomfortable | Painful |
|---|---|---|---|
| Lying down | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ |
| Stretching | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ |
| Running | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ |
| Lifting | ☐ | ☐ | ☐ |
| Kneeling | ☐ | ☐ | ☐ |
| Pulling | ☐ | ☐ | ☐ |
| Reaching | ☐ | ☐ | ☐ |
| Standing from a seated position | ☐ | ☐ | ☐ |
| Other ______________ | ☐ | ☐ | ☐ |

**Additional information / Any recent falls and/or injuries / Prior condition related medical history**

____________________________________
____________________________________
____________________________________
____________________________________
____________________________________
____________________________________

**What have you tried to help alleviate your condition?**

____________________________________
____________________________________
____________________________________
____________________________________
____________________________________