HARMONY CHROPRACTIC ARTS

WHERE ARE YOU NOW????

Please Complete

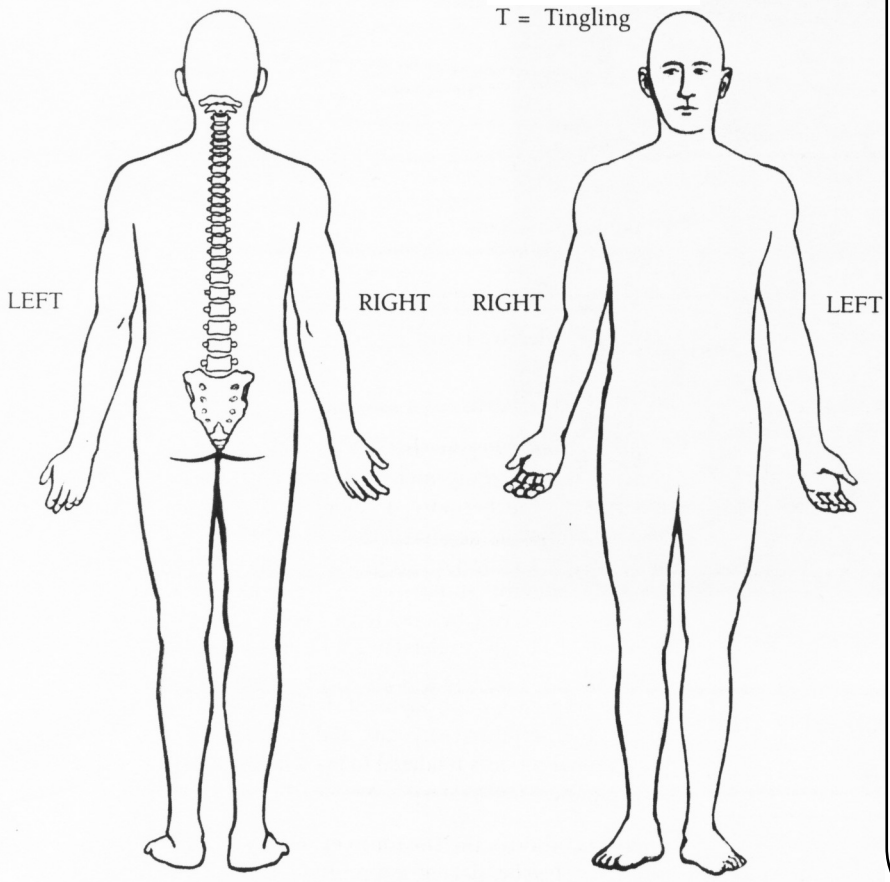
Name:_____ Date:_____

MARK PAIN AREA

+++ = Burning
000 = Stabbing
--- = Sharp
III = Constant
XXX = Other

MARK AREA

A = Ache
N = Numbness
P = Pain
S = Soreness
STF = Stiffness
T = Tingling



Please mark area of pain on the drawing using the code listed above.

SEVERITY OF DISCOMFORT/PAIN

List region of discomfort/pain and circle severity number (1 is low and 10 is high)

For Example: sharp

Neck 1 2 3 4 5 6 7 8 (9) 10

REGIONS

Headache	1	2	3	4	5	6	7	8	9	10
Neck	1	2	3	4	5	6	7	8	9	10
Shoulders - L R	1	2	3	4	5	6	7	8	9	10
Arms - L R	1	2	3	4	5	6	7	8	9	10
Mid Back	1	2	3	4	5	6	7	8	9	10
Low Back	1	2	3	4	5	6	7	8	9	10
Hips - L R	1	2	3	4	5	6	7	8	9	10
Legs - L R	1	2	3	4	5	6	7	8	9	10
Ankles - L R	1	2	3	4	5	6	7	8	9	10
Feet - L R	1	2	3	4	5	6	7	8	9	10
Mental/ Emotional Stressed Out	1	2	3	4	5	6	7	8	9	10

LIST YOUR FOUR MAJOR SYMPTOMS IN ORDER OF IMPORTANCE:

1._____

2._____

3._____

4._____

HELPS	POSITION	HURTS	HELPS	POSITION	HURTS	HELPS	POSITION	HURTS
❑	Bending Backward	❑	❑	Lying on Side	❑	❑	Walking	❑
❑	Bending Forward	❑	❑	Sitting	❑	❑	Other: Describe:	❑
❑	Bending Leg	❑	❑	Standing	❑			
❑	Driving	❑	❑	Stretching	❑			
❑	Lifting	❑	❑	Stretching Leg	❑			
❑	Lying Face Down	❑	❑	Turning Body	❑			
❑	Lying on Back	❑	❑	Turning Head	❑			

_____

_____

_____

_____

(Please fill out other side)

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Are there any other Systems involved with your current symptoms? (*Please check all boxes which apply)*

☐ Digestion	☐ Menstrual	☐ Immune System Challenges
☐ Elimination	☐ Pregnancy	☐ Colds
☐ Breathing	☐ Menopause	☐ Flu
☐ Circulation / Heart	☐ Sexual Dysfunction	☐ Other:_____
☐ Arthritis	☐ Energy Problems / Fatigue	☐ Other:_____
☐ Joint Pain	☐ Sleep Disturbances	☐ Other:_____

*(Please feel free to explain any of the above in further detail)*_____

_____

_____

_____

Do you currently have any other health issues, new symptoms, or problems? ***Please describe in detail below:***

_____

_____

_____

_____

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_____

Any other health issues you would like addressed? (*i.e. diet, exercise, weight control, detoxification, relaxation techniques, hormonal balancing, nutritional balancing, etc.)*

_____

_____

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_____

Thank you for your time and effort in filling out this form. It will be of great help to us in our efforts to provide the best possible health care for you.

Signature:_____