Pain Information

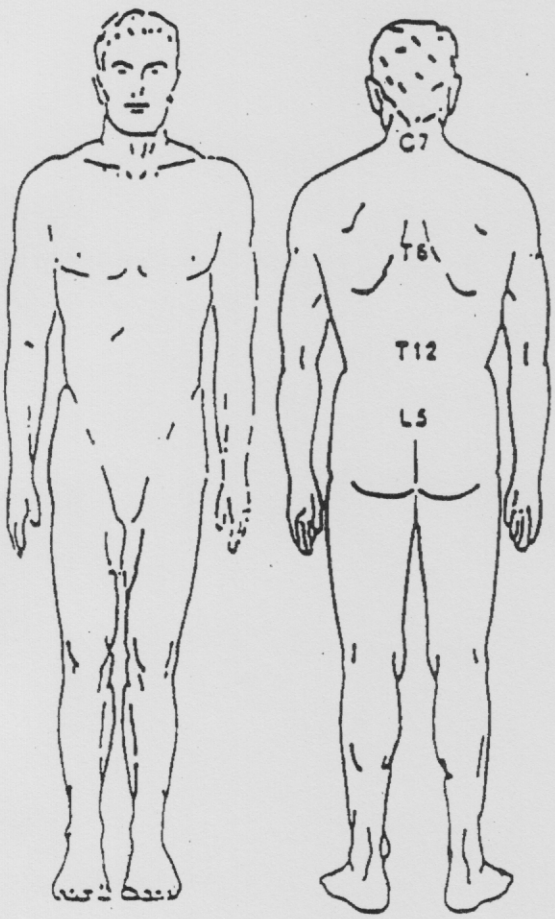
Name _____ Date _____
Address _____ City _____ Zip _____
Home Phone _____ Date of Birth _____

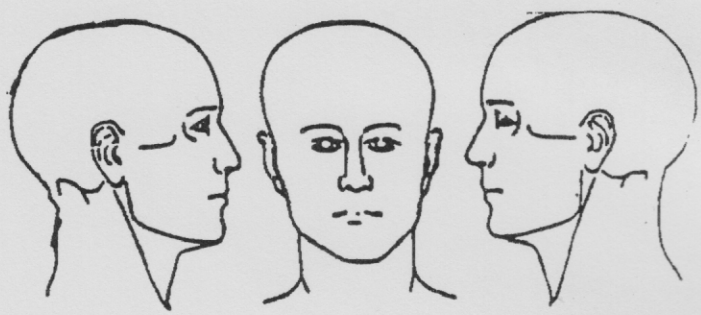
1. Please circle the description of your pain: ache, sharp, dull, numb, burning, stabbing, pin and needles, other

2. Please circle the level of pain that you are experiencing:

Absolutely pain free 1 2 3 4 5 6 7 8 9 10 Worst pain I've ever had

3. Please circle the body area(s) where you are hurting:





Thank you!
Gregory P. Brennan
Chiropractic Physician