

# Family Chiropractic Center

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Today's Major Complaint: Pain Scale of 0-10, 0=No Pain, 10=Extreme Pain PLEASE CIRCLE ONE**

• Neck Pain	0	1	2	3	4	5	6	7	8	9	10
• Shoulder Pain	0	1	2	3	4	5	6	7	8	9	10
• Arm Pain	0	1	2	3	4	5	6	7	8	9	10
• Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
• Low Back Pain	0	1	2	3	4	5	6	7	8	9	10
• Hip Pain	0	1	2	3	4	5	6	7	8	9	10
• Leg Pain	0	1	2	3	4	5	6	7	8	9	10
• Other: _____	0	1	2	3	4	5	6	7	8	9	10

**My condition affects my participation in the following activities: CIRCLE THOSE THAT APPLY**

• Sleeping	N/A	Minimal	Mild	Moderate	Severe
• Sitting	N/A	Minimal	Mild	Moderate	Severe
• Walking	N/A	Minimal	Mild	Moderate	Severe
• Standing	N/A	Minimal	Mild	Moderate	Severe
• Lifting	N/A	Minimal	Mild	Moderate	Severe
• Household Chores	N/A	Minimal	Mild	Moderate	Severe
• Routine Personal Care	N/A	Minimal	Mild	Moderate	Severe
• Driving	N/A	Minimal	Mild	Moderate	Severe
• Concentration	N/A	Minimal	Mild	Moderate	Severe
• Work	N/A	Minimal	Mild	Moderate	Severe
• Reading	N/A	Minimal	Mild	Moderate	Severe
• Headaches	N/A	Minimal	Mild	Moderate	Severe
• Recreation	N/A	Minimal	Mild	Moderate	Severe
• Other: _____	N/A	Minimal	Mild	Moderate	Severe

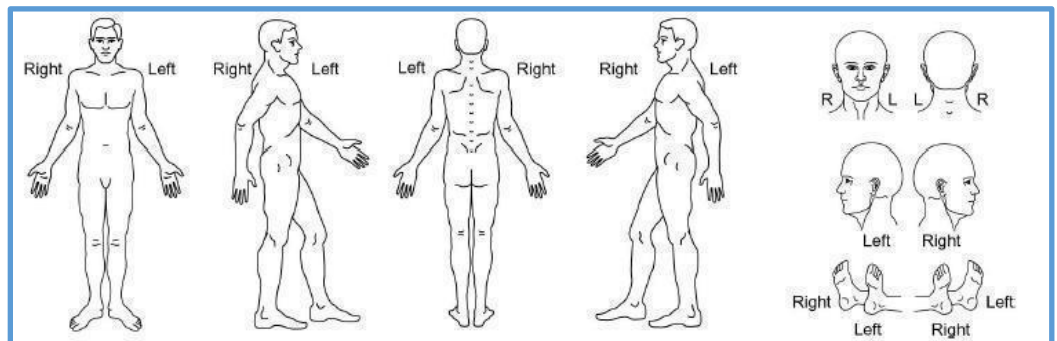
**Changing Degree of Pain**

- My pain is rapidly getting better
- My pain fluctuates but overall is getting better
- My pain seems to be getting better, but improvement is slow at the present
- My pain is neither getting better nor worse
  - My pain is gradually worsening
  - My pain is rapidly worsening

How long have you had pain? \_\_\_\_\_  
 Is this your first episode of pain? Y / N

Use the letters below to indicate the type and location of your sensations on the diagram to the right.

- A ~ Ache
- P ~ Pins and Needles
- B ~ Burning
- S ~ Stabbing
- N ~ Numbness



Signature: \_\_\_\_\_

Date: \_\_\_\_\_