



CHIROPRACTIC CHOICE LTD.

# Chiropractic Choice Patient Pain Form

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

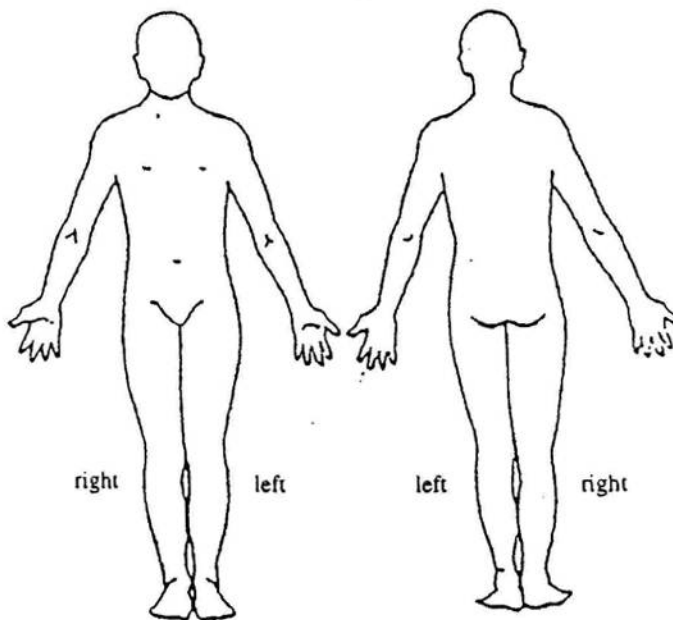
Date: \_\_\_\_\_

Claim No: \_\_\_\_\_

DOB \_\_\_\_\_

Using the symbols listed below, mark on the two drawings below which areas on your body where you feel the described sensations:

- Numbness                = = =
- Dull Ache                o o o
- Hot Burning             x x x
- Sharp Stabbing        / / /
- Pins and Needles      + + +
- Other \_\_\_\_\_
- \_\_\_\_\_



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

Physician Comments:

### Pain Scale:

Please rate the severity of the pain you have felt, in general, over the past few days by checking one box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
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