



Name: \_\_\_\_\_ File No. \_\_\_\_\_ Date \_\_\_\_\_

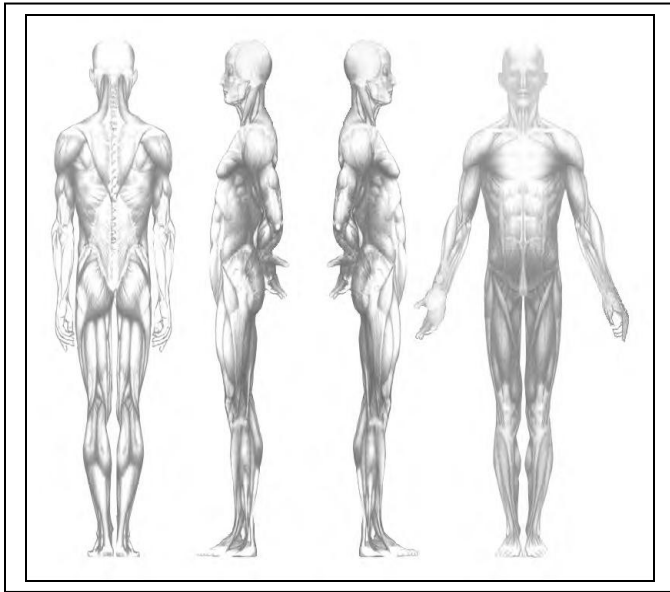
## Current Pain and Function Assessment Form

Please **mark** the location of your discomfort or health condition on the illustration below.

**KEY:** P = pain T = tender N = numb S = spasm R = radiating

Rate your pain on a scale from: Zero to 10 0= No Pain 10 = Extreme Pain (can't move)

[ 0 1 2 3 4 5 6 7 8 9 10 ]



1.) List your present condition:

\_\_\_\_\_

2.) Is your condition:

Improved  Same  Getting Worse

3.) Type of pain: (Please circle one or more)

Sharp - Dull - Numb - Burning - Spasming  
Throbbing – Shooting- Stiffness - Aching

4.) Current medications?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5.) How does this condition interfere with your work? \_\_\_\_\_

6.) How does this condition interfere with your home activity? \_\_\_\_\_

7.) How does this condition interfere with your exercise activity? \_\_\_\_\_

8.) What health goals are you trying to improve? \_\_\_\_\_

9.) What health goals are you trying to reach? \_\_\_\_\_

10.) What is your commitment level to become healthier and have better function if the doctor recommends further care? (**Circle one or more**) Pain Relief – Rehabilitation – Optimal health

11.) What is the nervous systems main function? \_\_\_\_\_

12.) Do you understand what a Subluxation is and how it can affect your health?

\_\_\_\_\_