Patient Update

Name: ______________________________ Date: ______________

After your last visit, how long were your symptoms improved: ______________________________

At the time of this visit, are you feeling ❒ better ❒ worse ❒ same compared to how you felt at your last visit?

Please describe: ______________________________

Symptoms improve with: ❒ rest ❒ activity ❒ heat ❒ cold ❒ therapeutic massage ❒ medication

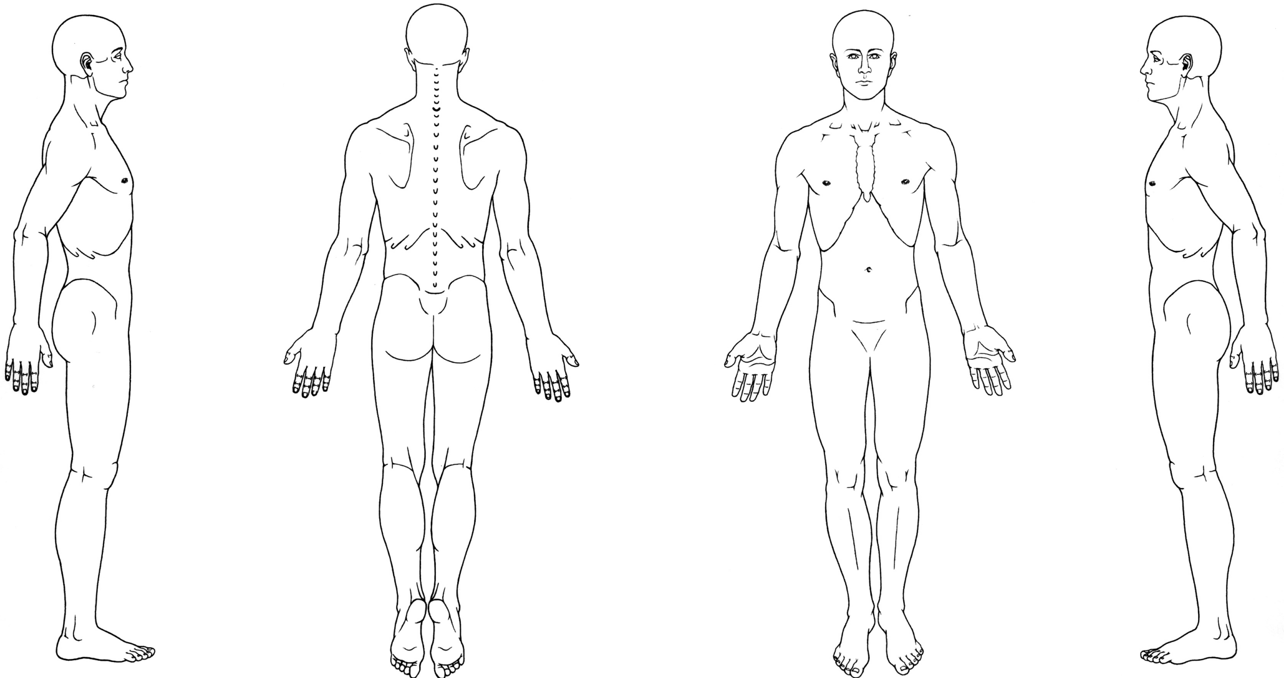
Symptoms worsen with: ❒ work ❒ standing ❒ sitting ❒ lying down ❒ activity ❒ exercise ❒ other: ______________

Since your last visit, have you experienced any of the following?

- ❒ headaches: frequency ______________ duration ______________ intensity ______________
- ❒ neck pain or stiffness: ______________________________
- ❒ shoulder pain or stiffness: ______________________________
- ❒ back pain or stiffness: ______________________________
- ❒ hip/pelvic pain or stiffness: ______________________________
- ❒ arm or leg pain or stiffness: ______________________________
- ❒ sleep difficulty: ______________________________

On a scale of 0 to 10, mark the level of pain you feel today on the figures below.

Please mark any current areas of numbness, dysfunction, discomfort, tingling, pins and needles, burning, aching, stabbing pain, spasm, stiffness, or preferred areas of focus and describe below:



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Patient's (or Guardian's) Signature