

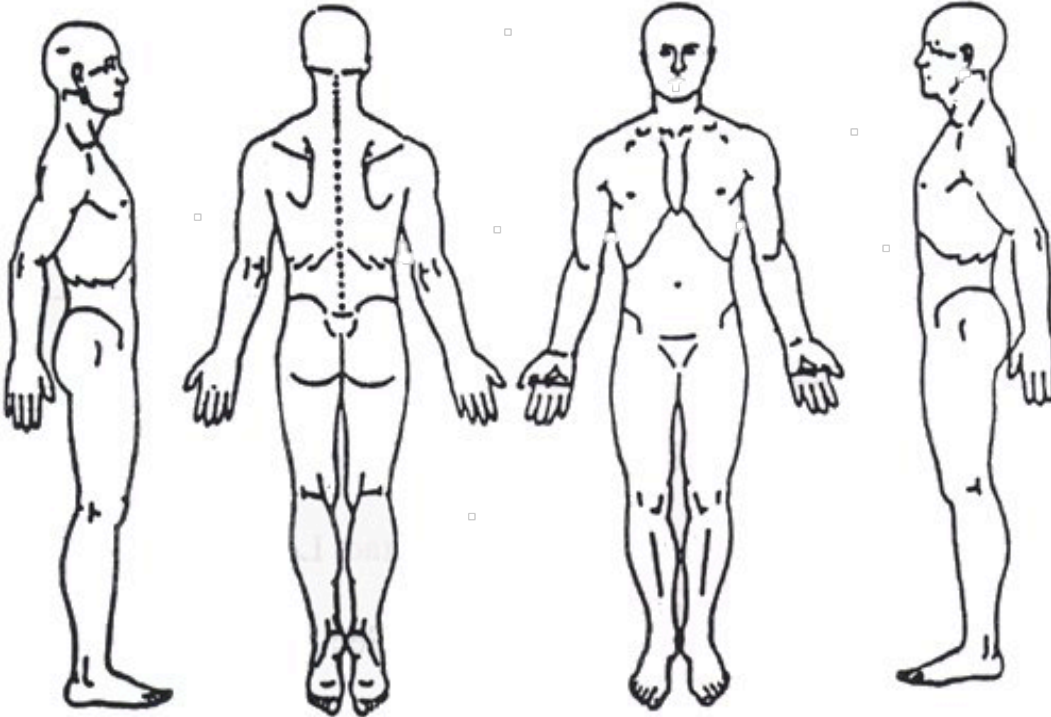
**It is important that this form is completed in full and brought with you to your first appointment**

**NAME:**

**DOB:**

Please explain the reason for your visit (e.g. back pain/unable to reach up, etc.)

Where does your pain occur? (Please mark on the diagram below with an 'X')



Please score each area of pain (on the diagram) from: 0 (No pain) to 10 (Extreme pain)  
Please mark on the any areas of numbness or pins and needles with an 'O'

Approximately how long have you been suffering with this pain? (Please circle one)

Less than < 1 week      1 week to 1 month      1-3 months      More than 3 months      More than 1 Year >

What caused your pain? (E.g. Car crash, fall, repetitive movement, sport, unknown, etc.)

<p>What activities worsen the pain? (E.g. bending, heavy lifting, sneezing, reaching up, etc.)</p> <div style="border: 1px solid black; height: 150px;"></div>	<p>What relieves your pain? (E.g. Pain killers, hot water bottle, stretching, etc.)</p> <div style="border: 1px solid black; height: 150px;"></div>
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