



Clark Chiropractic Clinic

Celebrating Good Health Through Natural Chiropractic Care

Body

Name: _____

Date: _____

How Long Have You Had This Pain? _____ Years _____ Months _____ Weeks _____ Days

Is This Your First Episode of Pain? _____ Yes _____ No

If not, how often does it occur? _____ Years _____ Months

**PLEASE MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATION.
USE THE APPROPRIATE SYMBOL AND MARK ANY AREAS OF RADIATING PAIN.
PLEASE INCLUDE ALL EFFECTED AREAS.**

Key: Burning (B) Numbness (N) Pins & Needles (PN) Sharp/Stabbing(S) Ache (A)

