

**Purpose for this appointment?:** \_\_\_\_\_

**How did this start?** \_\_\_\_\_ **When?** \_\_\_\_\_

**Have you ever had this problem in the past?**  Yes  No **When?** \_\_\_\_\_

**Has the problem been getting:**  Better  Worse  Staying the Same

**Does it occur:**  Constant  Daily  Intermittent  Night Only  Only with certain activities

**Is the pain:**  Sharp  Dull  Aching  Burning  Numb  Tingling  Other

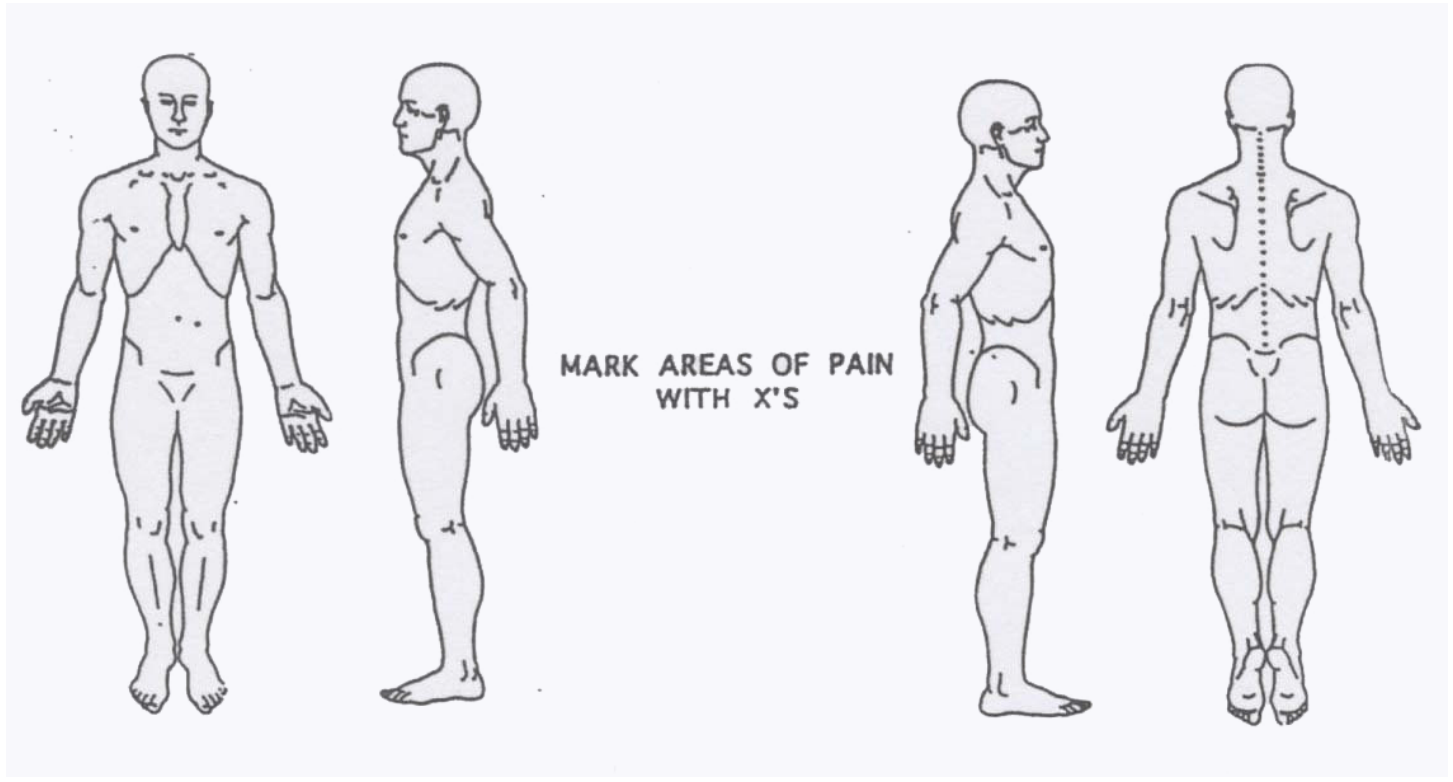
**What makes**

**the pain worse:**  Standing  Sitting  Laying  Bending  Lifting  Twisting  Other

**Is there anything that relieves the pain:** Yes No Describe: \_\_\_\_\_

Please rate your pain level on the scale (0 = no pain, 10 = worst pain, let's go to the ER)

0 1 2 3 4 5 6 7 8 9 10



I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Friedel responsible for errors or omissions that I may have made in the completion of this form.

If minor: I authorize Dr. Jena Friedel to perform exams and render chiropractic care/adjustments to my minor child, \_\_\_\_\_ . As of this date, I have the legal right to select and authorize healthcare services for the minor child named above.

Client Signature	Date:
Parent/Guardian Signature	Date: