

# SYMPTOM DIAGRAM

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

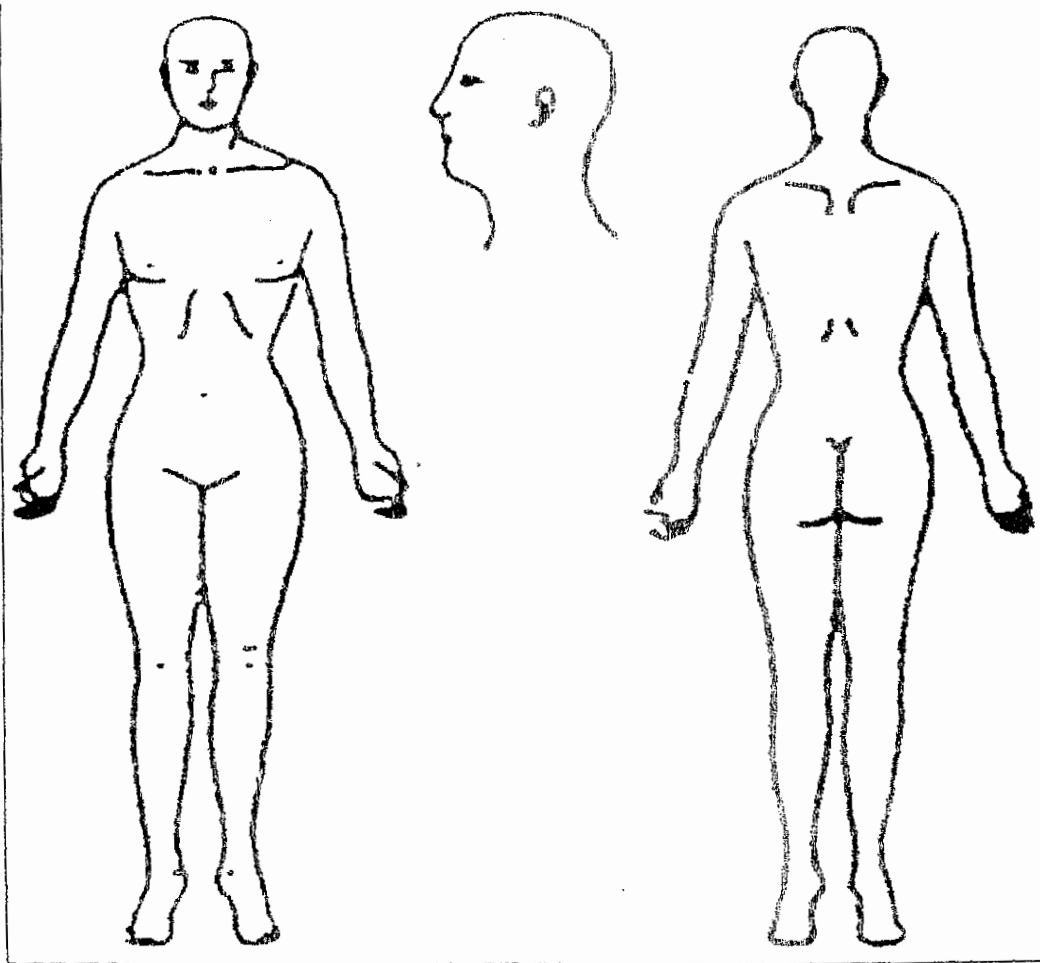
Aches \\\

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///



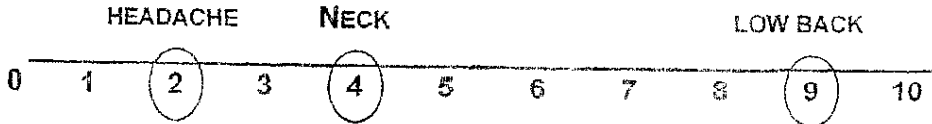
# QUADRUPLE VISUAL ANALOGUE SCALE

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

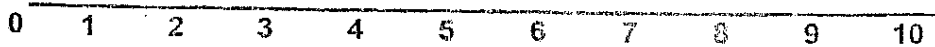
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

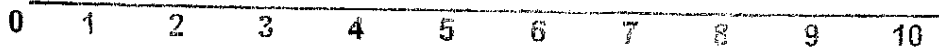
EXAMPLE:



1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

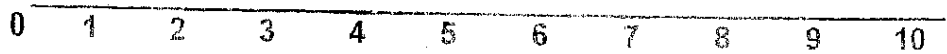


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? \_\_\_\_\_ %

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_ %

**Henderson Wellness Center, PA**  
414 Dabney Drive • Henderson, NC 27536

5<sup>th</sup> PROGRESS EVALUATION

Please answer the questions to the best of your ability. We will review any answers you don't know.

1. How does innate intelligence effect you?

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2. What does it mean when the skull, shoulder, or hips are out of alignment?

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3. Do you have any comments or complaints, either about your health or the office, that you would like us to address?

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4. How many times a week do you do your prescribed exercises?

None 1-2 days 3-5 days daily 2 times/day

5. How many times a week are you doing your cervical extension traction?

None 1-2 days 3-5 days daily 2 times/day