Health History

Date: ________________

Name: ___________________________________

Chief Complaint:

Where is the pain? ☐ Neck ☐ Mid-Back ☐ Lower ☐ Other

Is it getting better or worse? ____

Rate your pain where 1 is annoying and 10 is unbearable: _______________________________

How often do you experience this pain (0 to 100%): ____________________________________

What relieves the symptoms? ____

What makes them worse? ____

Other or New Symptoms:

Where is the pain? ☐ Neck ☐ Mid-Back ☐ Lower ☐ Other

Date it started: ________________ Where were you? __________________________________

Is it getting better or worse? ____

How is it affecting your daily life? ____

Is it worse with rest or activity? _______________ Time of day most frequent: ______________