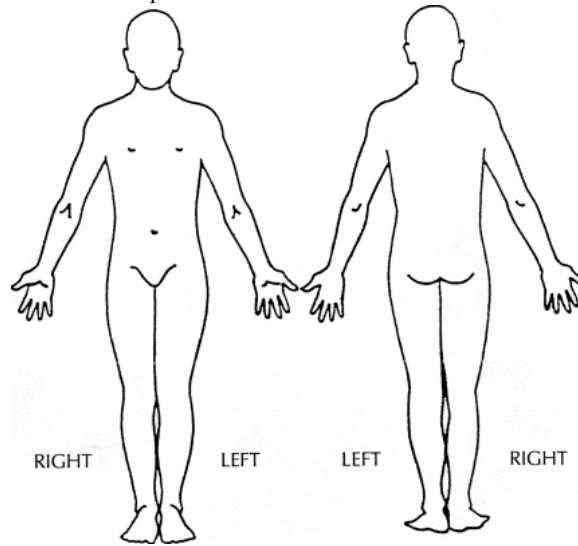


**MUSCULOSKELETAL**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pain in fingers          | <input type="checkbox"/> Bones sore/painful               | <input type="checkbox"/> Weakness                       |
| <input type="checkbox"/> Chronic pain             | <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Osteoporosis                   |
| <input type="checkbox"/> Joint pain or stiffness  | <input type="checkbox"/> Bone deformity                   | <input type="checkbox"/> Back pain                      |
| <input type="checkbox"/> Calcium deposits         | <input type="checkbox"/> Stiff in morning                 | <input type="checkbox"/> Athletic injury                |
| <input type="checkbox"/> Herniated / slipped disc | <input type="checkbox"/> Broken bones                     | <input type="checkbox"/> Tingling/burning in hands/feet |
| <input type="checkbox"/> Injure easily            | <input type="checkbox"/> Tendonitis                       | <input type="checkbox"/> Tightness in shoulder muscles  |
| <input type="checkbox"/> Pain in arms / hands     | <input type="checkbox"/> spasms /cramps /restless muscles | <input type="checkbox"/> Swollen knees/elbows           |
| <input type="checkbox"/> Loss in height           | <input type="checkbox"/> Numbness in the extremities      | <input type="checkbox"/> Unable to sit straight         |
| <input type="checkbox"/> Double-jointed           | <input type="checkbox"/> Pain in neck and/or shoulders    | <input type="checkbox"/> Bursitis                       |

**PAIN**

Please mark any areas of discomfort in the pictures below



How long have you had this pain? \_\_\_\_\_  
 Quality of pain (eg. Sharp, stabbing, burning achy, dull ect.) \_\_\_\_\_  
 Is this pain constant or does it come and go? \_\_\_\_\_  
 How frequently do you have pain \_\_\_\_\_

Is your pain better or worse with...(B for better/ W for worse):

- |                      |             |
|----------------------|-------------|
| ___ Movement         | ___ Rest    |
| ___ Heat             | ___ Cold    |
| ___ Pressure/Massage | ___ Morning |
| ___ Afternoon        | ___ Evening |

**Rate your pain 0-10**

