ACTIVE CARE
CHIROPRACTIC
ALIGNMENT • NUTRITION • MOVEMENT

PAIN DRAWING

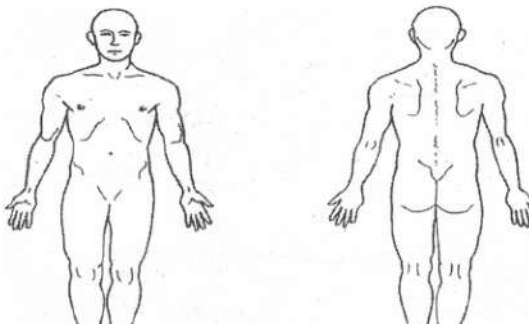
NAME: _____ DATE: _____

SHOW US WHERE YOU'RE EXPERIENCING PAIN

Mark the areas on the body diagrams where you are experiencing pain or discomfort. Include all affected areas.

LIST YOUR THREE PRIMARY CONCERNS:

1. _____
2. _____
3. _____



Burping After Meds	_____	Weight Loss/Gain	_____	Feet Cold/ Hands Cold	_____
Fatigue	_____	Ulcers	_____	Arthritis	_____
Broken Bones/Fractures	_____	Loss of Memory	_____	Muscle Spasms	_____
Rheumatoid Arthritis	_____	Circulation Problems	_____	Frequent Colds	_____
Osteoarthritis	_____	Seizures/Epilepsy	_____	Fever	_____
Pacemaker	_____	Osteoporosis	_____	Sinus Problems	_____
Stroke	_____	Heart Disease	_____	Indigestion Problems	_____
Drug Addiction	_____	Cancer	_____	High Blood Pressure	_____
Headaches	_____	Coughing Blood	_____	Difficulty Urinating	_____
Sleeping Problems	_____	Alcoholism	_____	Weakness in Extremities	_____
Nervousness	_____	Depression	_____	Dizziness When Standing	_____
Tension	_____	Loss of Balance	_____	Sinus Problems	_____
Irritability	_____	Fainting	_____	Indigestion Problems	_____
Chest Pains/Tightness	_____	Loss of Smell	_____	Joint Pain/Swelling	_____
Dizziness	_____	Loss of Taste	_____	Menstrual Difficulties	_____
Shoulder/Neck/Arm Pain	_____	Unusual Bowel Patterns	_____	Pre/Peri Menopause	_____
Numbness- Fingers/Toes	_____	Diabetes	_____	Brain Fog	_____

CURRENT DRUGS/MEDICATION:

_____

_____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT HEALTH/WELLBEING.

- ☐ I AM ONLY CONCERNED ABOUT RELIEF OF A PARTICULAR SYMPTOM.
- ☐ I AM ONLY CONCERNED ABOUT RELIEF OF A PARTICULAR SYMPTOM, AND PREVENTING ITS RETURN.
- ☐ I WANT OPTIMUM HEALTH AND WELLBEING ON EVERY LEVEL AVAILABLE TO ME.

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