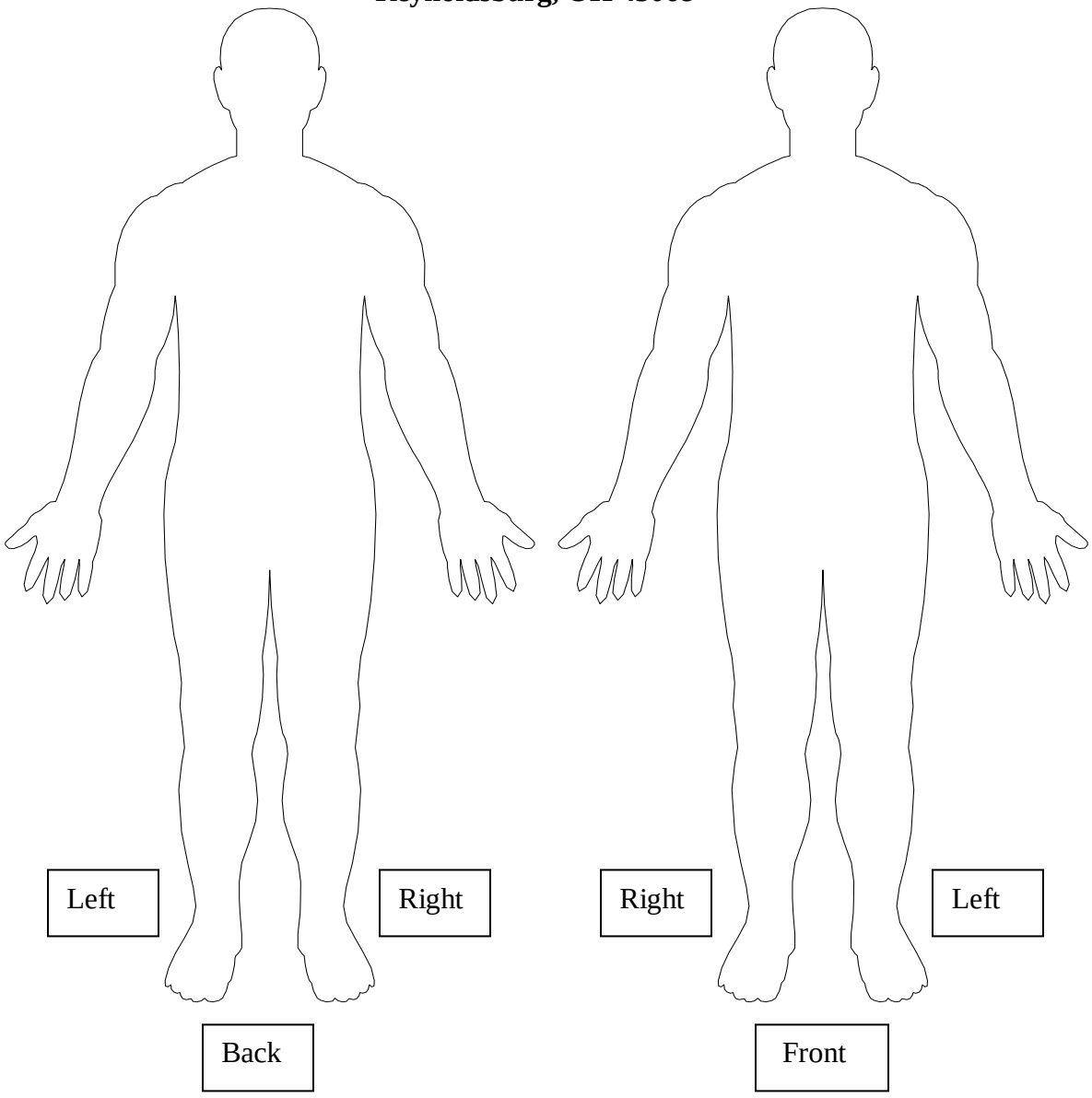
OYLER CHIROPRACTIC
7539 E. Main St.
Reynoldsburg, OH 43068



Using the symbols listed below, mark on the two drawings above the areas on your body where you feel the described sensations:

Numbness	= = =	Hot Burning	x x x
Dull Ache	o o o	Sharp Stabbing	/ / /
Pins and Needles	+ + +	Other_____	

Patient Signature: _____ Date: _____
Case Number:_____

(Please see reverse side for pain scale and sign where indicated)

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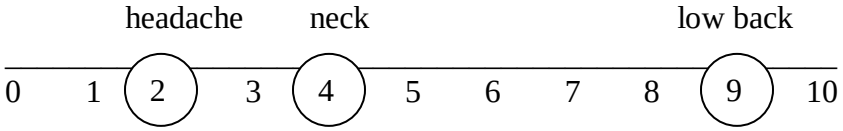
VISUAL ANALOG SCALE

INSTRUCTIONS: Please circle the number (0 = no pain; 10 = unbearable pain) 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:



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1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

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

NAME: _____ DATE: _____
Case Number:_____