Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #:_____

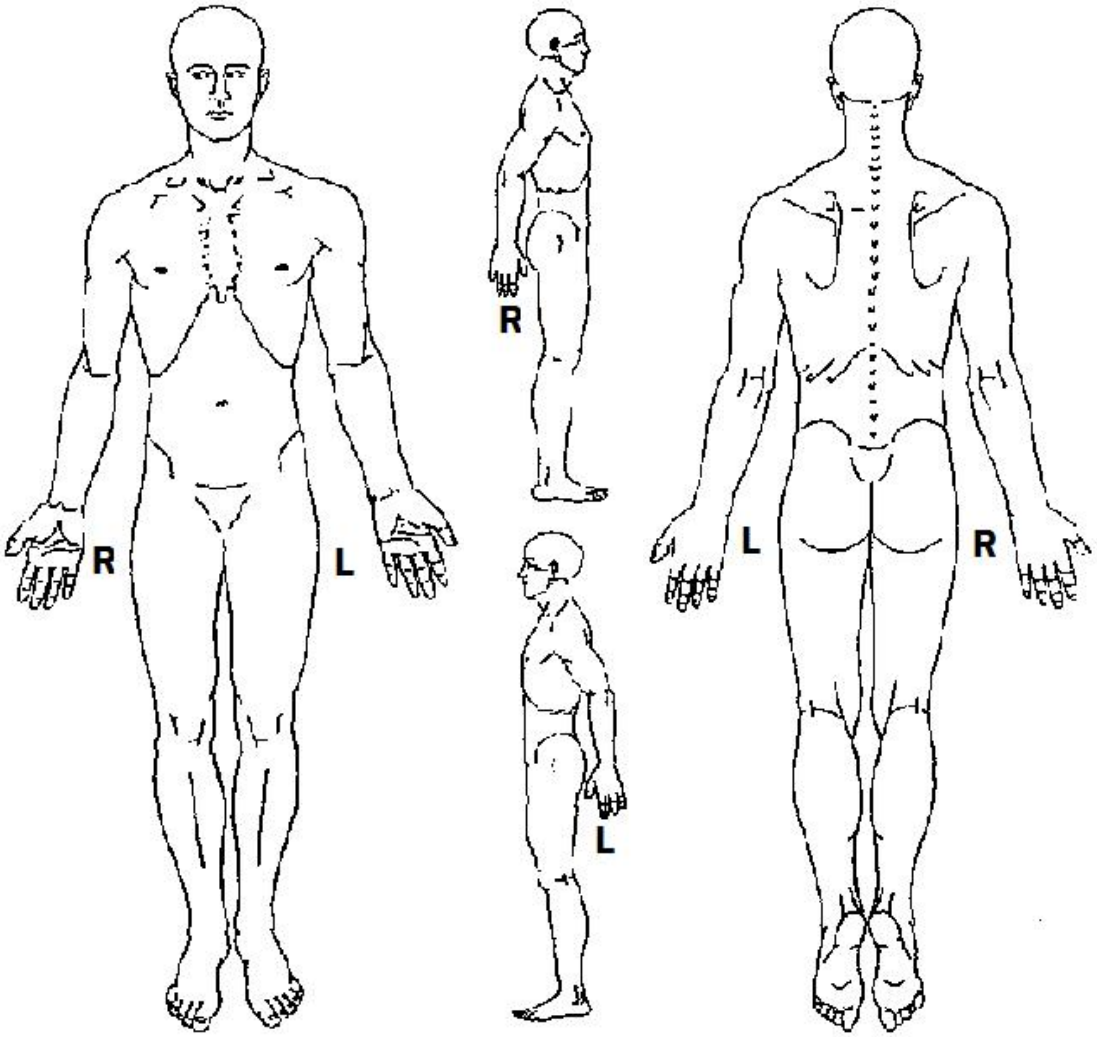
PAIN DRAWING

PAIN SCALE: On a scale of 1-10, please CIRCLE A NUMBER on the scale to indicate your level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

Describe DETAILS and LOCATION of your pain:
Draw the following letters on the diagram below; indicating the LOCATION of your pain and the TYPE of pain sensations you are experiencing right now. If you have multiple areas of pain, you may also write the PAIN SCALE number (0 through 10) next to each area of your pain on the diagram.

A = Ache
B = Burning
N = Numbness
P = Pins and Needles
S = Stabbing
O = Other _____



*** OVER PLEASE ***

Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #:_____

AREA OF INVOLVEMENT – Physical Complaints

AREA OF INVOLVEMENT 1: _____ Level of pain (0=no pain - 10=Worst pain imaginable): # _____
(Location/area of your body)
HOW OFTEN: Constant / Frequent / Intermittent / Occasional / Gradual or Insidious onset _____ ago
SEVERITY: Very Severe / Mild / Mild to Moderate / Moderate / Moderately Severe / Severe / Worse or Better at night / Worse or Better in AM / Worse or Better during the day
MOVEMENT: Inflexibility / Restricted Movement / Stiffness
SENSATIONS: Crawling / Dead / Numb / Pins and needles / Prickly / Tingling
PAIN TYPES: Aching / Burning / Dull / Excruciating / Numb ache type / Pounding / Sharp / Shooting / Stabbing / Stinging / Throbbing
AREA: Generalized in, Localized in / Migrating to / Radiating to / Shooting into _____
AGGRAVATED BY: Coughing / Sneezing / Straining at BM's / Arising from a chair / Bending / Carrying / Climbing a ladder / Climbing stairs / Driving / Exercising / Getting out of bed / Getting in and out of the car / Lifting / Pulling / Pushing / Reclining / Repetitious movements / Sitting / Standing / Stooping / Walking uphill / Walking / Emotional upset / Stress
RELIEVED BY: Having chiropractic adjustments / Taking Advil / Aspirin / pain pills / Tylenol / Exercising / Resting / Sitting / Sleeping / Walking / Cold / Massaging by hand / Heat / Rubbing heat liniment / Hot showers / Mineral ice / Nothing / Tub soak / Massaging with vibrator / Stretching

AREA OF INVOLVEMENT 2: _____ Level of pain (0=no pain) - (10=Worst pain imaginable): # _____
(Location/area of your body)
HOW OFTEN: Constant / Frequent / Intermittent / Occasional / Gradual or Insidious onset _____ ago
SEVERITY: Very Severe / Mild / Mild to Moderate / Moderate / Moderately Severe / Severe / Worse or Better at night / Worse or Better in AM / Worse or Better during the day
MOVEMENT: Inflexibility / Restricted Movement / Stiffness
SENSATIONS: Crawling / Dead / Numb / Pins and needles / Prickly / Tingling
PAIN TYPES: Aching / Burning / Dull / Excruciating / Numb ache type / Pounding / Sharp / Shooting / Stabbing / Stinging / Throbbing
AREA: Generalized in, Localized in / Migrating to / Radiating to / Shooting into _____
AGGRAVATED BY: Coughing / Sneezing / Straining at BM's / Arising from a chair / Bending / Carrying / Climbing a ladder / Climbing stairs / Driving / Exercising / Getting out of bed / Getting in and out of the car / Lifting / Pulling / Pushing / Reclining / Repetitious movements / Sitting / Standing / Stooping / Walking uphill / Walking / Emotional upset / Stress
RELIEVED BY: Having chiropractic adjustments / Taking Advil / Aspirin / pain pills / Tylenol / Exercising / Resting / Sitting / Sleeping / Walking / Cold / Massaging by hand / Heat / Rubbing heat liniment / Hot showers / Mineral ice / Nothing / Tub soak / Massaging with vibrator / Stretching

AREA OF INVOLVEMENT 3: _____ Level of pain (0=no pain) - (10=Worst pain imaginable): # _____
(Location/area of your body)
HOW OFTEN: Constant / Frequent / Intermittent / Occasional / Gradual or Insidious onset _____ ago
SEVERITY: Very Severe / Mild / Mild to Moderate / Moderate / Moderately Severe / Severe / Worse or Better at night / Worse or Better in AM / Worse or Better during the day
MOVEMENT: Inflexibility / Restricted Movement / Stiffness
SENSATIONS: Crawling / Dead / Numb / Pins and needles / Prickly / Tingling
PAIN TYPES: Aching / Burning / Dull / Excruciating / Numb ache type / Pounding / Sharp / Shooting / Stabbing / Stinging / Throbbing
AGGRAVATED BY: Coughing / Sneezing / Straining at BM's / Arising from a chair / Bending / Carrying / Climbing a ladder / Climbing stairs / Driving / Exercising / Getting out of bed / Getting in and out of the car / Lifting / Pulling / Pushing / Reclining / Repetitious movements / Sitting / Standing / Stooping / Walking uphill / Walking / Emotional upset / Stress
RELIEVED BY: Having chiropractic adjustments / Taking Advil / Aspirin / pain pills / Tylenol / Exercising / Resting / Sitting / Sleeping / Walking / Cold / Massaging by hand / Heat / Rubbing heat liniment / Hot showers / Mineral ice / Nothing / Tub soak / Massaging with vibrator / Stretching

Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #:_____

UPDATE HEALTH HISTORY

1. List all medications or drugs you are currently taking- include dosage and strength- and reason for use.
   Medication: How much? How often?

2. Do you take any vitamins/minerals/ other nutritional supplements?
   Supplement: How much? How often?

3. Have you experienced a trauma, fall or motor vehicle accident in the past 12 months?

4. Have you experienced any of the following in the past 12 months?
   Job change or retirement Death in family (Elaborate on relation below) Divorce or Separation

5. Have you experienced any changes in digestion and/or urination?

6. Have you experienced any changes in menstruation (women only)?

7. Have you experienced any health issues since last visit to this office?

8. Have you been hospitalized or had surgery since your last visit?

9. Do you currently smoke cigarettes? YES NO
10. Do you currently drink alcohol? YES NO
11. Do you use recreational drugs? YES NO
12. Do you exercise? NEVER DAILY WEEKLY
13. Please list all activities you perform (ex. Walk, run, swim, bike)

Dr. Robert E. Monokian Date: _____

Pt Name: _____ File #:_____

CURRENT INFORMATION - UPDATE FORM

PLEASE PRINT:

Please help us verify that we have your most current information:

YOUR CURRENT PHONE NUMBER/S: We like to have all three numbers.

Home: _____

Work: _____

Cell: _____

What company is your Cell Phone Carrier? ATT / Sprint / Other _____

YOUR CURRENT PLACE OF EMPLOYMENT: _____

YOUR CURRENT EMAIL ADDRESS: _____

YOUR CURRENT MAILING ADDRESS: _____

_____

_____

YOUR CURRENT INSURANCE INFORMATION

Name of INSURANCE CARRIER: _____

Phone # of Insurance Carrier: _____

Subscriber/Member ID # _____

Name of Group of plan: _____

Group/Plan # _____

Name of Insured: _____

Insured's Date of Birth: _____

Patient's Relationship to Insured: Self, Spouse, Child Other: _____

Insured's Employer: _____

Please give your most CURRENT INSURANCE CARD to the front desk
so we can make a copy for our records.
THANK YOU!

REVISED 7/09/2015