PATIENT PAIN FORM

Please fill out the left side of this sheet for Dr. Turley

Today's Date: ______________________________________
Patient Name: ______________________________________

YOUR PAIN SEVERITY AND FREQUENCY HAS BEEN?

On a scale of 1-10 my pain level is a:
0 1 2 3 4 5 6 7 8 9 10

I have pain (% of the time):
0%, 10%, 25%, 50%, 75%, 100%

INDICATE PAIN SEVERITY (Use 0 to 10 Levels)
_______ My *overall* pain level *today*
_______ My *most severe* pain *today*
_______ My *least* level of pain *today* (0 = NONE)

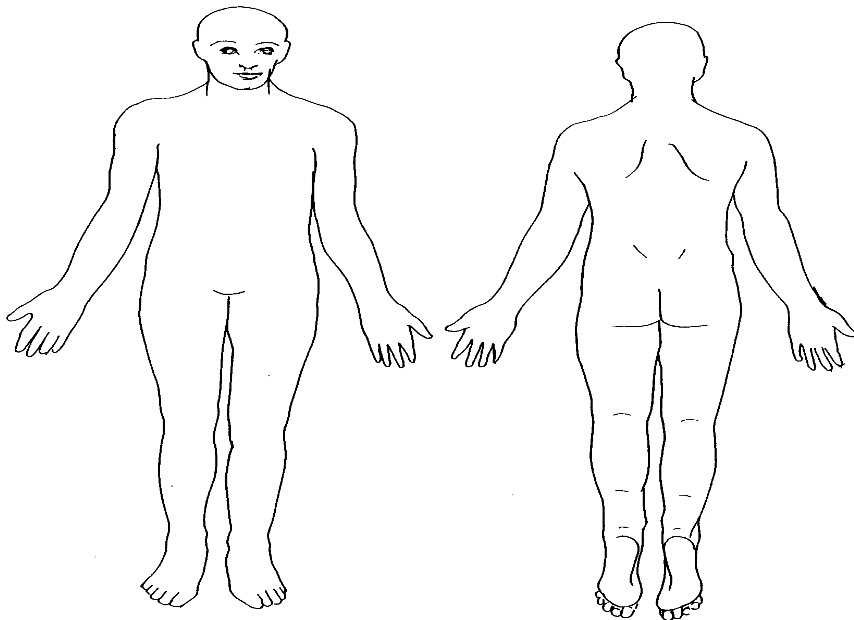
Have you had any new injuries ☐ No, ☐ Yes
If yes, describe: ______________________________________

Have you had any new sensations or pain ☐ No, ☐ Yes
If yes, describe: ______________________________________

PAIN DRAWING

MARK WHERE YOU HAVE PAIN OR ALTERED SENSATION

P = Pain/Soreness	T = Tingling	B = Burning	N = Numbness	S = Stiffness



TURLEY CHIROPRACTIC CLINIC
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PROGRESS NOTES

S:______________________
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O:______________________
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A:______________________
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P:______________________
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