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How did you hear about Greenwich Integrative Medicine?

- Internet Search News Media Family/Friend Referral From Another Patient
 Health Extensions Physician Referral Lecture Access Circles Other: _____

Patient Information:

Name: _____
(Last) (First) (Middle)

Mailing Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Sex: _____ Marital Status: _____

Occupation: _____ Employer: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Email: _____

May we leave a message? Yes No

Please indicate with asterisk the best telephone number to call for appointment confirmation or to contact you directly.

My primary care physician is: _____ Phone: _____

Primary care physician's address: _____
(Street) (City) (State) (Zip)

May we contact your primary care physician? Yes No

Referring Physician: _____ Phone: _____

In case of emergency please notify:

Name: _____ Relationship: _____

Emergency Contact Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Other: _____

Patient Registration (continued)

Responsible Party Information: Please complete any information different from patient information.

Name:

(Last)

(First)

(Middle)

Mailing Address:

(Street)

(City)

(State)

(Zip)

Relationship to the patient: Spouse Parent/Guardian Other

Home Phone: ()

Cell Phone: ()

Work Phone: ()

Insurance Information (Required)

(Please provide us with your insurance card)

Primary Insurance Plan:

Effective Date:

Claim Office Address:

Insured ID #:

Group Name:

Policy/Group #:

Name of Insured (required):

(Last)

(First)

Social Security#:

Patient Relationship to Insured:

Home Phone: ()

Cell Phone: ()

Secondary Insurance Plan:

Effective Date:

Claim Office Address:

Insured ID #:

Group Name:

Policy/Group #:

Insured's Name (required):

(Last)

(First)

Patient Relationship to Insured:

Home Phone: ()

Cell Phone: ()

Other:

Workers Compensation: Yes No

Motor Vehicle Accident: Yes No

Currently on Disability: Yes No

Pending Litigation on Medical Problems: Yes No

Patient Registration (continued)

Patient History

All questions in this questionnaire are strictly confidential and will become part of your medical record.
Please add additional sheets if necessary.

What are your chief medical problems and symptoms at this time?

What are your goals for treatment at Greenwich Integrative Medicine?

Hospitalization: None

Please list any significant medical illness or diagnosis that required hospitalization:

Year	Reason	Hospital

Surgical History: None

Year	Reason	Hospital

Do you frequently use:

- | | | | | | |
|------------------------|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|
| Antibiotics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Steroids | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Birth Control Pills | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Acid Regulators | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cholesterol Medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Over-the-Counter Pain Relievers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient Registration (continued)

Current Medications: None

Medication	Dosage	Frequency

Current Supplements: None

Indicate Brand If Known

Known allergies to medication, foods, others (latex, insect bites, environment, etc.)

Immunization Report (You may attach the immunization record.)

Immunization Name	Immunization Dates
Hib	
Pneumococcal	
Polio	
MMR	
DPT	
Varicella	
Influenza	
Preumovax	
HBV	
HAV	
Meningitis	
Rabies	
TB Test	

Patient Registration (continued)

Medical Diagnosis History

Please check off all of your diagnoses made by a health care provider.

- Acne
- Alcoholism
- Allergies/Hay Fever
- Alzheimer's Disease
- Anemia
- Anxiety
- Arthritis
- Asthma
- Autoimmune Disease
- High Blood Pressure
- Bronchitis
- Cancer
Type _____
- Carpal Tunnel Syndrome
- Cholesterol, Elevated
- Chronic Fatigue Syndrome
- Circulatory Problems
- Colitis
- Constipation
- Dental Problems
- Depression
- Diabetes
- Digestive Disorders
- Diverticular Disease
- Drug Addiction
- Eating Disorder
- Eczema
- Emphysema
- Environmental Sensitivities
- Epilepsy
- Eyes, Ears, Nose, Throat Problems
- Fibromyalgia
- Food Intolerance
- Gastroesophageal Reflux Disease
- Genetic Disorder
- Glaucoma
- Gout
- Heart Disease

- Heart Murmur
- Herpes
- Hepatitis
- Infection, Chronic
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Kidney or Bladder Disease
- Learning Disabilities
- Leukemia
- Liver or Gallbladder Disease
- Lupus
- Lyme
- Mental Illness
- Mental Retardation
- Migraine Headaches
- Mononucleosis
- Multiple Sclerosis
- Neurological Disorders
Type _____
- Parkinson's

- Obesity
- Osteoporosis
- Pneumonia
- Polio
- Seasonal Affective Disorder
- Seizures
- Sexually Transmitted Disease
- Sleep Apnea
- Sinusitis
- Stroke
- Thyroid Disease
- Hypothyroid
- Hyperthyroid
- Tuberculosis
- Ulcer
- Urinary Tract Infection
- Varicose Veins
- Other

Patient Registration (continued)

Family Health History

Please check all that apply to your family

- | | | | | | |
|--|-----------|-----------|------------|-----------|----------|
| <input type="checkbox"/> Alcoholism | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Alzheimer's Disease | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Anxiety | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Arthritis | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Asthma | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Autoimmune Disease | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Cancer(s) | ___Father | ___Mother | ___Brother | ___Sister | ___Other |

Type

- | | | | | | |
|---|-----------|-----------|------------|-----------|----------|
| <input type="checkbox"/> Depression | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Diabetes | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Drug Addiction | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Eating Disorder | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Emphysema | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Epilepsy/Seizures | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Food Sensitivities | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Genetic Disorder | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Glaucoma | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Heart Disease | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> High Blood Pressure | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Infertility | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Learning Disorder | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Menstrual Irregularity | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Mental Illness | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Mental Retardation | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Migraine Headaches | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Obesity | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Osteoporosis | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Polycystic Ovaries | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Sexual Transmitted Disease | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Stroke | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Suicide | ___Father | ___Mother | ___Brother | ___Sister | ___Other |
| <input type="checkbox"/> Thyroid Disease | ___Father | ___Mother | ___Brother | ___Sister | ___Other |

Indicate those family members that are deceased, age of death, and cause of death.

Family Members	Age of Death	Cause of Death
Father	_____	_____
Mother	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____

Patient Registration (continued)

General Health

Check off all symptoms that currently apply:

Rank all symptoms you experience in the space provided next to the symptom as follows:

0 – Almost never have symptoms

1 – Occasionally - Effect not severe

2 – Occasionally – Effect is severe

3 – Frequently – Effect is not severe

4 – Frequently – Effect is severe

SYMPTOMS RANK (0–4)

- Frequently Ill _____
- Fever or Chills _____
- Weight Gain _____
- Weight Loss _____
- Loss of Appetite _____
- Change in Appetite _____
- Fatigued _____
- Lack Stamina _____
- Apathetic _____
- Lethargic _____
- Hyperactive or Agitated _____
- Angry or Irritable _____
- Sweat Easily _____
- Night Sweats _____
- Bruise or Bleed Easily _____
- Incapable of Experiencing Pleasure _____
- Suffer from Complete Exhaustion _____
- Depressed/Anxious _____
- Feeling of Worthlessness or Guilt _____
- Difficulty Concentrating _____
- Memory Loss or Forgetfulness _____
- Recurrent Thoughts of Death or Suicide _____
- Considered a Nervous Person _____
- Cold Intolerance _____
- Heat Intolerance _____
- Increased Thirst _____
- Treated for an Emotional Illness Yes No

SKIN: RANK (0–4)

- Dry Skin _____
- Oily Skin _____
- Frequent Break Outs _____
- Itching _____
- Hives _____

- Unwanted Hair Grown _____
- Rash _____
- Change in Moles (Color, Size, Shape) _____
- Skin Growths/Lumps _____
- Hair Loss _____
- Skin Sensitive or Reactions _____
- Ulcerations _____
- Stretch Marks _____
- Significant Changes In Hair or Nails _____
- Recent Change Skin Color (Light/Dark) _____
- Do you tan? Yes No
- Change in Color/ Hurts in Cold Yes No

EYES: RANK (0–4)

- Blurred Vision _____
- Double Vision _____
- Blind Spots _____
- Dry Eyes _____
- Itchy or Watery Eyes _____
- Dark Circles _____
- Cataracts _____
- Swollen/Red Eyes _____
- Infections _____
- Date of Last Eye Exam _____/_____/_____
- Eye Surgery or Laser Treatment Yes No
- Wear Glasses Yes No
- Wear Contact Lenses Yes No

EARS: RANK (0–4)

- Ear Problems _____
- Ringing in Ears _____
- Ear Pain _____
- Ear Infection _____
- Date of Last Hearing Test _____/_____/_____

NOSE AND THROAT: RANK (0–4)

- Sinus Problems _____
- Nosebleeds _____
- Recurrent Sore Throats _____
- Infections _____
- Mouth Sores _____
- Hoarseness or Change in Voice _____
- Significant Alteration in Taste or Smell _____
- Nasal Polyps _____
- Runny Nose _____
- Dental Problems/Extensive Dental Work/Cavities _____
- Bleeding Gums _____
- Stuffy Nose _____
- Tongue Coating _____
- Difficulty Swallowing _____
- Persistent Cough _____
- Sneezing _____
- Grind Your Teeth Yes No

CHEST: RANK (0–4)

- Asthma or Wheezing _____
- Pain with Deep Respiration _____
- Shortness of Breath at Rest With Exertion or at Night _____
- Excessive Phlegm _____
- Cough Up Blood _____
- Difficulty Breathing When Lying Down _____
- Chest Congestion _____
- Date of Last Chest X-Ray _____/_____/_____
 - Normal Abnormal

Patient Registration (continued)

Check off all symptoms that currently apply:

Rank all symptoms you experience in the space provided next to the symptom as follows:

0 – Almost never have symptoms

1 – Occasionally - Effect not severe

2 – Occasionally – Effect is severe

3 – Frequently – Effect is not severe

4 – Frequently – Effect is severe

HEART: RANK (0–4)

- Heart Problems _____
- Heart Attack _____
- Leg or Ankle Swelling _____
- Blood Clots _____
- Experience Thumping, Racing or Skipping of the Heart _____
- Rapid or Pounding Heartbeat _____
- Irregular or Skipped Heartbeat _____
- Chest Pain or Discomfort _____
- Number of Pillows You Sleep On _____
- Date of Last EKG
____/____/____
 Normal Abnormal

GASTROINTESTINAL: RANK (0–4)

- Trouble Swallowing _____
- Bad Breath _____
- Heartburn _____
- Nausea _____
- Vomiting _____
- Abdominal Pain _____
- Ulcer _____
- Liver Problems _____
- Jaundice _____
- Diarrhea _____
- Constipation _____
- Bloating Feeling _____
- Use Laxative
Type _____
How Often _____
- Hemorrhoids or Rectal Problems _____
- Rectal Pain _____
- Black or Bloody Stools _____
- Colon Polyps _____
- Belching _____
- Flatulence (Gas) _____
- Last Sigmoidoscopic Exam
____/____/____

GENITOURINARY: RANK (0–4)

- Frequent Urination _____
- Frequent Night Urination _____
- Burning Pain While Urinating _____
- Blood in Urine _____
- Bladder or Kidney Infection _____
- Kidney Stone _____
- Trouble Starting or Stopping Urine Flow _____
- Incontinence _____
- Venereal Disease
Type _____
- Difficulty with Dribbling _____

BONES AND JOINTS: RANK (0–4)

- Movement Limitation _____
- Joint Pain or Stiffness _____
- Joint Swelling or Redness _____
- Back Pain That Limits Your Activities _____
- Severe Neck Pain _____
- Muscle Weakness _____
- Muscle Tenderness _____
- Muscle Cramps with Walking or at Night _____
- Broken Bones/Stress Fractures _____
- Muscle Gain with Weights/Workout _____
- Muscle Pain _____

NEUROLOGICAL: RANK (0–4)

- Frequent or Severe Headaches _____
- Fainting or Loss of Consciousness _____
- Seizures or Convulsion _____
- Balance Problem _____
- Dizziness/Lightheadedness _____

- Difficulty Walking _____
- Poor Coordination _____
- Numbness or Tingling in Arms or Legs _____
- Tremors _____
- Shooting Pains _____
- Loss of Strength _____
- Loss of Bowel or Bladder Control _____

SLEEP: RANK (0–4)

- Feel Rested Upon Waking _____
- Feel Tired Upon Waking _____
- Difficulty Falling Asleep _____
- Difficulty Staying Asleep _____
- Wake Up Middle Night _____
- Difficulty Falling Back to Sleep _____
- Nightmares or Night Terrors _____
- Normal Bed Time Hour _____
- Normal Wake Time Hour _____
- Time of Mid-Night Waking _____
- Snore Yes No
- Stop Breathing During Sleep Yes No

MEN ONLY:

- Shave Less Than Usual Yes No
- Morning Erections Yes No
- Difficulty with Erections or Ejaculation Yes No
- Change in Prostate Yes No
- Decreased Sexual Interest Yes No
- Growth of Breast Tissue Yes No
- Last Prostate Exam
____/____/____

Patient Registration (continued)

WOMEN ONLY:

- Age at the Time of Your First Period _____
- Are your periods regular? Yes No
- Period Every _____ Days
- Length Monthly Cycle _____ (days)
- Date of Your Last Menstrual Period _____/_____/_____
- Are you pregnant? Yes No
- Light or Heavy Flows Yes No
- Painful Cycles Yes No
- Uterus Removed Yes No
If Yes, When _____
Why _____
- Currently Using Birth Control Yes No
Type _____
How Long _____
- Previously Used Birth Control Yes No
Type _____
How Long _____
- Have you ever had a fertility problem? Yes No
- Date of Last Mammogram _____/_____/_____
 Normal Abnormal
- Other than noted above, have you ever had an abnormal mammogram? Yes No
- Do you get routine mammograms? Yes No
- Date of Last PAP Smear: _____/_____/_____
 Normal Abnormal
- If abnormal, were you treated? Yes No
- Have you had a uterine ultrasound? Yes No
- Do you have any history of D&Cs? Yes No
- Number of Full-Term Pregnancies _____
- Number of Miscarriages _____
- Complications During Pregnancy Yes No

- Insufficient or Excessive Weight Gain During Pregnancy Yes No
- Able to Lose the Extra Weight After Each Pregnancy Without Dieting Yes No
- Gestational Diabetes Yes No
- Breast Tenderness, Lumps or Discharge Yes No
- Have you been exposed to DES? Yes No
- Periods Resume Normally After Each Pregnancy Yes No
- Bone Mineral Density Study Yes No
- Vaginal Dryness Yes No
- Decreased Sexual Interest Yes No
- Decreased Sexual Satisfaction Yes No

YOUR CHILDHOOD HEALTH:

- Full Term Yes No
- Birth Complication Yes No
- Breast Fed Yes No
- Bottle Fed Yes No
- History of Ear Infections Yes No
- History of Throat Infections Yes No
- History of Eczema, Atopic Dermatitis Yes No
- History of Allergies Yes No
- History of Asthma Yes No
- History of Digestive Disorder Yes No
- Immunizations Up To Date Yes No
- Met All Developmental Milestones Yes No
- Learning Challenges Yes No
- Unusual Response to Textures, Smells, Temperature Yes No
- Unusual Growth Patterns Yes No
- Infant Colic Yes No

SOCIAL HABITS:

Check all that pertain to current or recent use.

- Tobacco
- Caffeine
- Alcohol
- Sodas
- Diet Sodas
- Sweets/Desserts
- Artificial Sweeteners
- Diet Pills
- Antidepressants
- Fruit Juices
- Milk/Milk Substitutes (Rice Dream)
- Number Cups Coffee/Day
Regular _____
Decaffeinated _____
- Number cups Tea/Day
Hot _____
Cold _____
- Number Sodas/Week
Regular _____
Diet _____
- Number Glasses Fruit Juice/Day _____
- Number Glasses Milk/Day _____
- Number Glasses Juice or Milk Substitutes/Day _____
- Number Sweets/Desserts/Day _____
- Number Items of Artificial Sweeteners/Day _____
- Smoke Cigarettes (Including Past) Yes No
Number of Years _____
Number Packs/Day _____
- Smoke Cigars Yes No
Number Cigars/Day _____
Number Cigars/Week _____
- Use Nicotine Gum Yes No
How Long _____
- Nicotine Patches Yes No
Which Patch _____
How Long _____
- Chew Tobacco Yes No
How Long _____
- Tried Cutting Any of Above Unsuccessfully Yes No
Last Time Tried to Quit _____

Patient Registration (continued)

SOCIAL HABITS (continued):

- Currently Taking Diet Pills Yes No
Type _____
Dose _____
Frequency _____
- Experimented With/Used Social Drugs Yes No
- History of Radiation or Radiation Therapy Yes No
- Exposed to Asbestos Yes No
- List other toxic exposure:

- List travels to developing countries:

- Lived in a House Older Than 20 Years Old Yes No
- Any Exposure to Mold Yes No
- Where do you get your water?
 City supply Well
- Do you wear seatbelts? Yes No

EXERCISE/ACTIVITY:

- Is your job: Active Sedentary
- Number Hours a Day You are Sitting Down (Including Travel Time) _____
- Number Hours in Front of a Computer _____
- On average how much time a day do you exercise?
 0 min. 15 min.
 30 min. 45 min.
 1 hr. 1 hr. 15 min.
 1 hr. 30 min. 1 hr. 45 min.
- Age of Mattress _____
 Comfortable Uncomfortable
- Wear Heel Lifts Yes No
- Sole Lifts Yes No
- Orthotics Yes No
- Happy with How Your Body Looks Yes No
- Describe Your Exercise/Activity (Including Gardening/Housework/ Yardwork, Etc.)

ALCOHOL CONSUMPTION:

- Was there a period you drank more than you currently do? Yes No
- Ever Felt You Should Cut Down on Your Alcohol Consumption Yes No
- Ever Considered Stopping Yes No
- Ever Experienced Blackouts Yes No
- Prone to Binge Drinking Yes No
- Defensive When People Criticize Your Drinking Yes No
- Feeling Guilty About Your Drinking Yes No
- Have to Drink First Thing in Morning to Steady Your Nerves or Reduce Hangover Yes No

STRESS QUESTION:

- Are under a new acute stress? Yes No
- Are you under a constant chronic stress? Yes No

Please assess your stress level on a scale of 1 to 10 (1=LOWEST to 10=HIGHEST)

- Family _____
- Finances _____
- Work _____
- Personal _____
- Illness _____
- Travel _____
- Do you wake in the middle of the night thinking about things that happened during the day? Yes No
- Do you feel the stress you are under is within your control? Yes No
- Number Hours You Work in a Day (Including Taking Care of Children) _____

- Number Days/Week You Work _____
- How long is your commute to work? Hours _____ Minutes _____
- Travel Extensively for Work Yes No
- If the definition of stress is not having enough hours in the day to take care of yourself, are you under stress? Yes No
- Feel Dissatisfaction/Frustration with Life Yes No
- Feel Dissatisfaction/Frustration with Work Yes No
- Feel Dissatisfaction/Frustration with Family Yes No
- Happy With Your Achievements Yes No

STRESS MANAGEMENT:

Check all the items that pertain to how you handle stress:

- Exercise
- Yoga
- Take Baths/Jacuzzi
- Other Forms Movement
- Go for Long Walks/Hikes
- Read
- Meditate
- Take Regular Vacations
- Comfort Food
- Talk with Family/Friend
- Watch TV/Movies
- Sleep
- See a Counselor
- Support Groups
- Take Medication
- Play with Pets
- Get Body Work (Massage, Facial, Etc.)
- Drink Alcohol
- Other _____

Patient Registration (continued)

DIET HISTORY:

■ Number Meals Consume/Day _____

■ Do you skip meals? Yes No

■ Which of the following best describes your meal pattern?
 Mostly Eating Out and On the Go
 Constantly Dieting

A Balance of Carbohydrates, Fats, Proteins and Vegetables

Vegetarian/Vegan

None of the Above

Please Describe:

■ Ever Been on a Diet Yes No
 List Every Diet:

■ Reason for the Diet:

■ Happy with your Current Weight Yes No
 If Not, Why:

■ Ever Eliminated Foods From Your Diet Yes No

■ What Kinds of Foods or Items You Crave

Sweets/Sugar Chocolate

Salt Alcohol

Breads, Pasta and Other Starches

Other _____

■ Check the Flavors You Strongly Like

Salty Sweet

Sour Bitter

Pungent/Spicy

■ Check the Flavors You Strongly Dislike

Salty Sweet

Sour Bitter

Pungent/Spicy

■ Vegetables Included in Your Meals Yes No

■ Number of Glasses of Water You Drink a Day _____

■ Describe a Usual:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please check the challenges that apply:

Frequently Eat Out

Frequently Travel

Dislike Healthy Food

Do Not Read Labels

Crave Sweets/Starches

Crave Fats

Crave Junk Food

Crave Fast Food

Eat in the Car

Don't Like or Have Time to Cook

Eat Under Stress

Eat as Reward

Emotional Eater

Eat in the Middle of the Night

Graze on Food All Evening

Eat Out of Boredom

Eat in Order to Stay Awake or Alert

Family Members Have Significant Dietary Constraints

Eat Quickly

Eat Everything That is in Front of Me Even Though I Am Full

Compelled or Disgusted by Taste

Indicate on the Figure Where You Have Pain or Symptoms

Indicate Intensity:

1=None — 10=Unbearable

1 2 3 4 5 6 7 8 9 10

