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Name:		Date of Birth:	
Condition related to:	Employment	Auto Accident	Other
Date condition/injury began		Date of Surgery:	_
Please list any medication you are co	ırrently taking.		
Medication		Milligrams	
	_		_ _
	<u> </u>		_
	Pain S Please Rate		
1 2 Mild	3 4 5 Mod	6 7 8 9 10 derate Extreme	
The state of the s	Fan A	Which of these words des  (Check all that apply)  Sharp Dull  Aching Ting  Constant Vari  On the model to the left pof the body where your page.	Burning ling Numb lable Radiating lease shade the area
*Note*Places understand that your r	pain will probably fluor	yets as the source of your treatment progr	raccas. If your
	atment is not necessary	uate as the course of your treatment program. Neither of these conditions is s reason sits prescribed by your doctor.	
Signature (Parent if Patient is minor	)	 Date	