



Dr. Dave W. Pool, B.S., D.C.  
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## Current or Chief Complaint

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for visit

\_\_\_\_\_

When did it start?

\_\_\_\_\_

How did it happen?

\_\_\_\_\_

What increases your pain?

\_\_\_\_\_

What gives you the greatest relief?

\_\_\_\_\_

### Rate your pain

No pain

worst pain ever

0    1    2    3    4    5    6    7    8    9    10

Does your pain move from one place to another?

Yes \_\_\_\_\_ No \_\_\_\_\_

Do you find it difficult to do any of the following:

Work \_\_\_ Sleep \_\_\_ Sit \_\_\_ Stand \_\_\_ Walk \_\_\_ Bend Over \_\_\_ Lay  
Down \_\_\_

Anything else you would like for Dr. Pool to know about

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Indicate what type of pain you are having:**

Sharp\_\_\_\_ Dull\_\_\_\_ Throbbing\_\_\_\_ Tingling\_\_\_\_  
Cramping\_\_\_\_ Swelling\_\_\_\_ Stiffness\_\_\_\_ Burning\_\_\_\_  
Stabbing\_\_\_\_ Aching\_\_\_\_ Numbness\_\_\_\_ Shooting\_\_\_\_

**Mark on the diagram below where you are having pain**

