

Canton, MI 48187
734-981-6969

Patient Name _____ Date _____ Patient Number _____

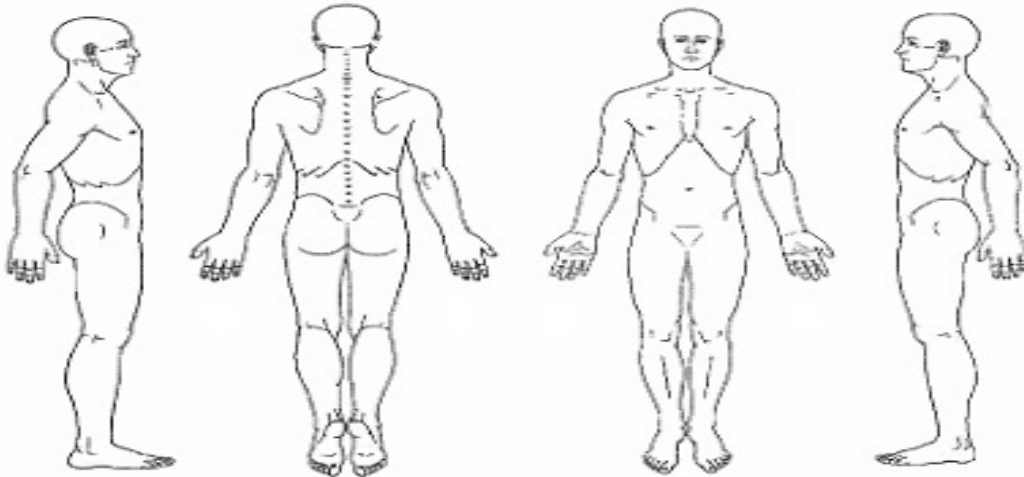
1. Please describe your symptoms _____

a. When did your symptoms start? _____
b. What caused your symptoms? _____

2. What best describes the nature of your symptoms?
 Sharp Shooting Dull ache
 Burning Numb Tingling

3. Who have you seen for your symptoms?
 No one Chiropractor
 Medical Doctor Physical Therapist Other

4. Using the drawings, mark areas of concern:



Patient Signature _____ Date _____

If minor, authorizing Signature _____ Date _____