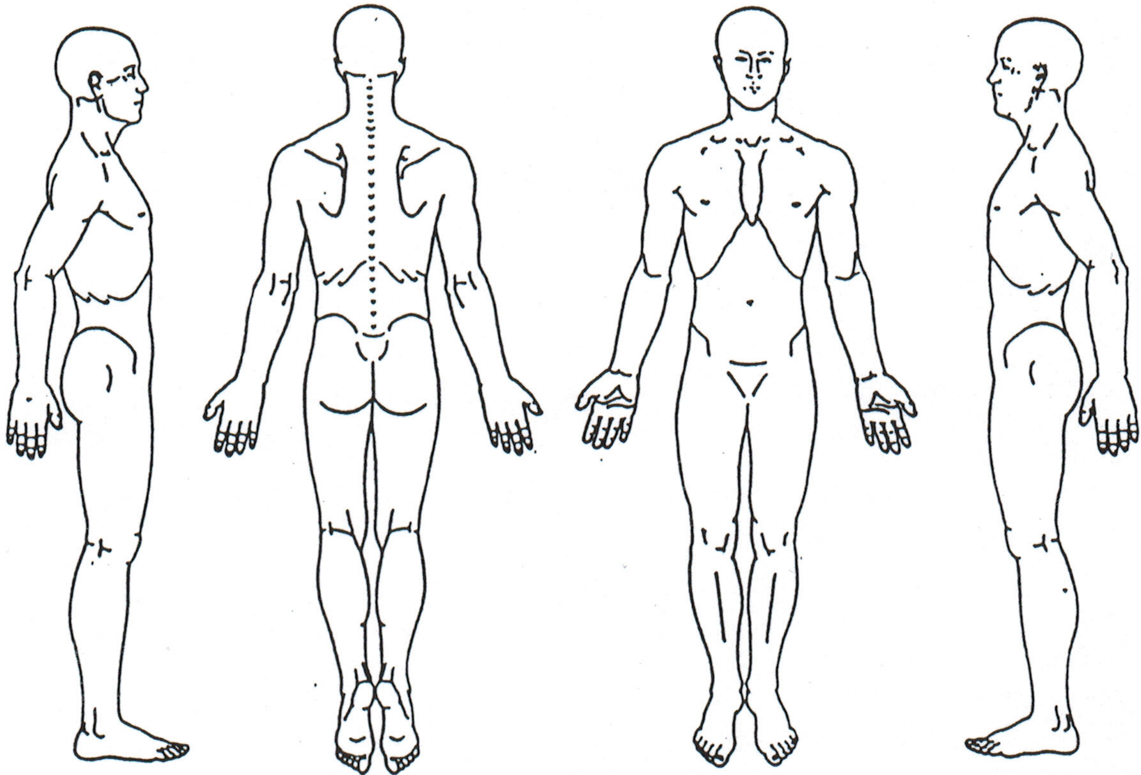
West Bay Chiropractic Center, P.C.

Daily Patient Record

Patient Name________________________________Date____________Time____________

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull *NNN*   Stabbing/Cutting *////*   Burning *XXX*   Tingling (pins & needles) *::::*   Cramping *SSS*



Using the scale 0-100, with 0 = no pain and 100 = worst possible pain, please write the number indicating your present pain level in the box at the right: ☐

Place one mark on the line below to indicate your present pain level:

No pain____Worst pain

Please indicate in the appropriate box below how you have felt since your last visit:

☐ Much better   ☐Better   ☐Same   ☐Worse   ☐ Much worse

Please note any changes in your condition in this space:

Patient Signature____