

Lawlor Chiropractic

Injury Form

Name		Date	
What is your complaint?			
When did it start?			
How did it start (BE SPECIFIC)?			
Where is the symptom?			
Where does it travel?			
Describe the symptom? Sharp Dull Aching Burning Numb Throbbing Radiating Deep			
How severe is it? 1-2-3-4-5-6-7-8-9-10			
How often do you have it? Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%			
What makes it better or worse?			
What movements are difficult?			
What have you done for this already?			
Patient's Signature		Date	