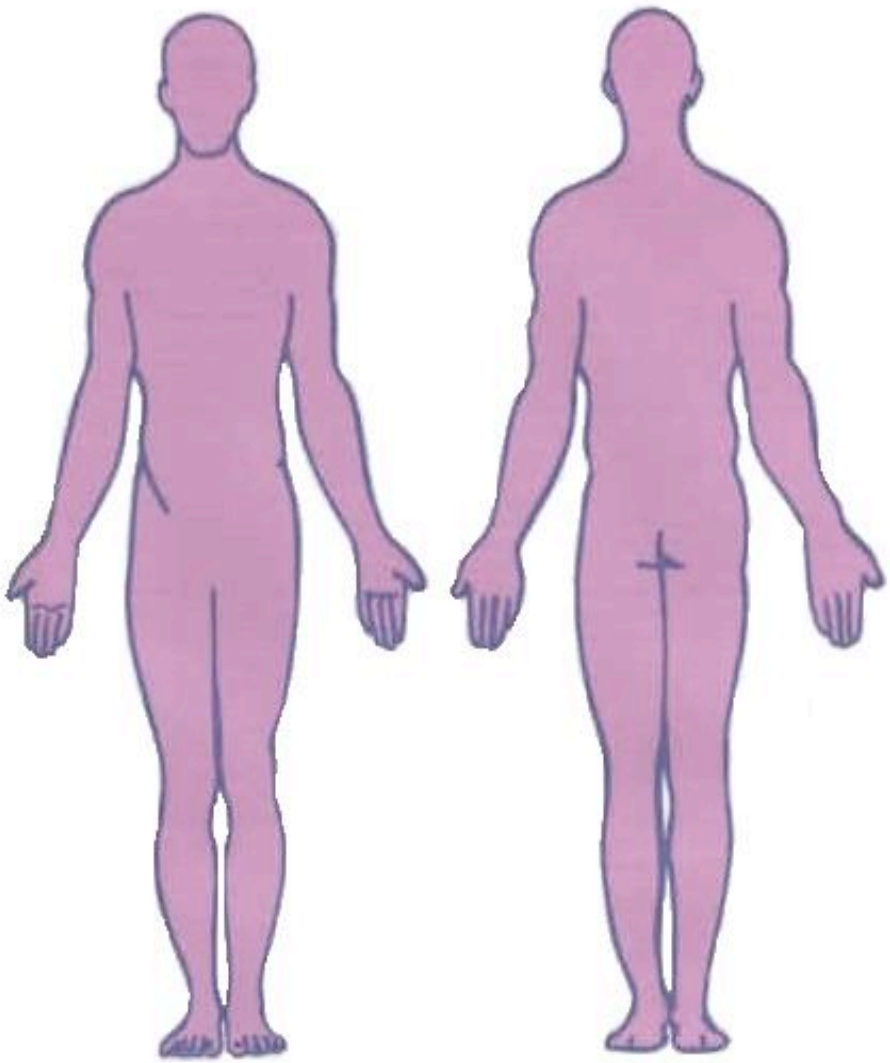
SALINA
CHIROPRACTIC

Name: _____ Date:_____

PLEASE MARK OR SHADE THE AREAS OF YOUR BODY WHERE YOU FEEL PAIN ON THE DIAGRAMS BELOW.



0	No Pain
1	Mild Pain; you are aware of it but it doesn't bother you.
2	Moderate pain that you can tolerate without medication.
3	Moderate pain that requires medication to tolerate.
4-5	More severe pain; you begin to feel antisocial.
6	Severe pain.
7-9	Intensely severe pain.
10	Most severe pain; unbearable.

CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

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