Name: _____

Form Completion Date: _____ Date of Medical Visit: _____

Visit Priorities

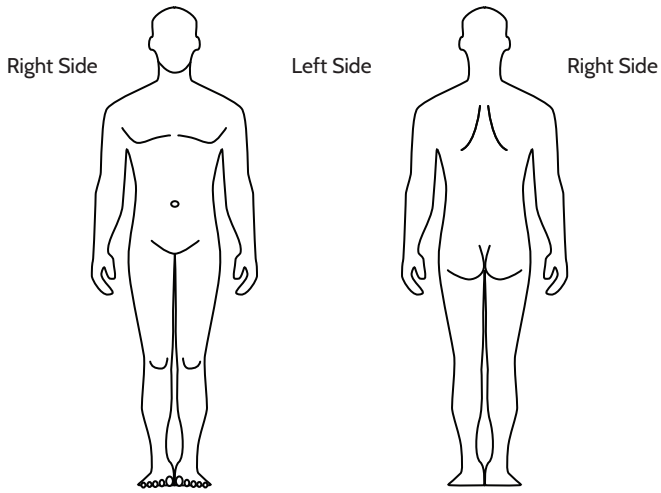
Describe the top two points you want to work on or discuss during your upcoming visit:

1.

2.

Pain Diagram

Please color in 'red pen' all areas of pain



Current Symptom Scores

Please circle the number that best describes how you have been feeling in the last week (or how you typically feel).

SYMPTOM	Best										Worst
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Brain Fog	0	1	2	3	4	5	6	7	8	9	10
Body Aches	0	1	2	3	4	5	6	7	8	9	10
Pain	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Sleep Problems	0	1	2	3	4	5	6	7	8	9	10

Hours of Upright Activity

How many hours/24hr day do you spend with feet on the floor (sitting, standing, walking)? _____

How many hours/24 hr day do you spend with feet elevated (feet propped up, reclined, sleeping)? _____

Note: The two answers above should add up to 24 hours