

general informations

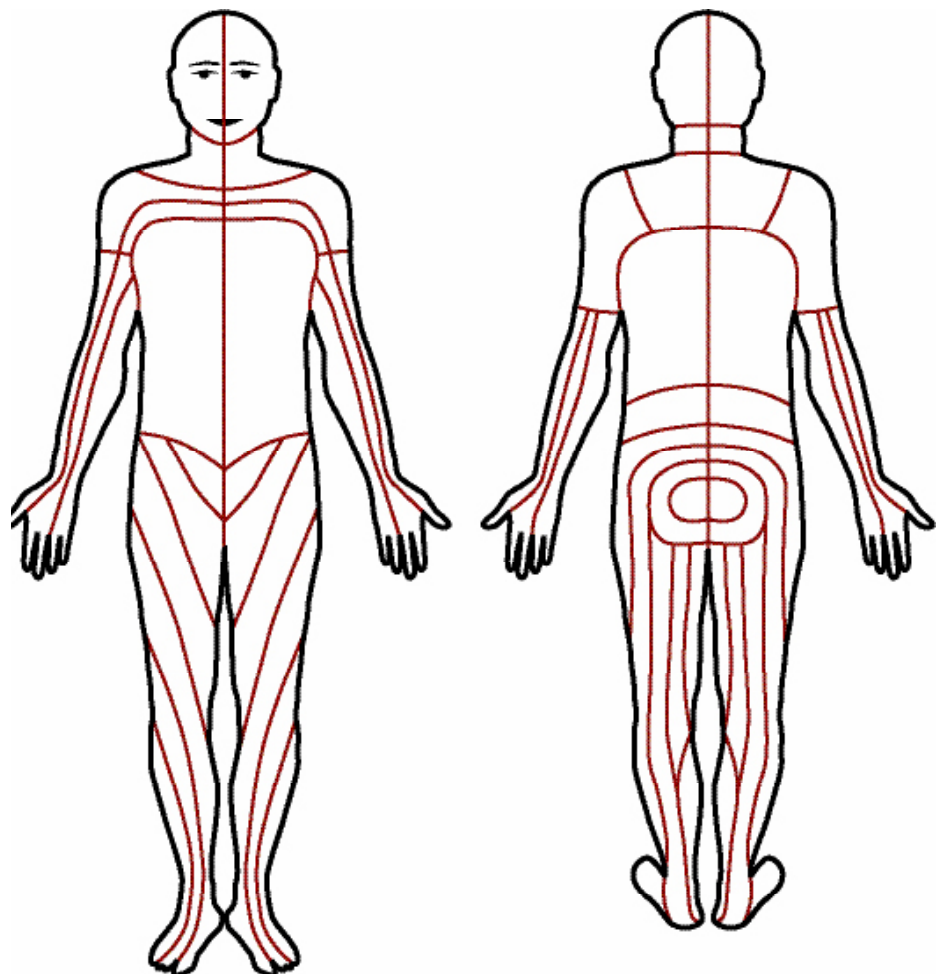
first name	surname
date of birth	
adress	city
country	

contact informations

phone	fax
mobile	e-mail

your pain areas

Where in your body is the pain located?



Your health complaints

I have the current complaints since _____

What aggravates the pain _____

What reduces the pain _____

The pain goes into my sholder arm finger

I have pain in my arm left right no

Are you having pain at night often little no

Does the pain increase when you turn your head left right

The pain increases when I bend forward I bend backward

Have you got headaches often sometimes no

What kind(s) of treatment have you had so far and what was the result _____

Results of the last MRI or CT scan _____

Please add further informations and results!