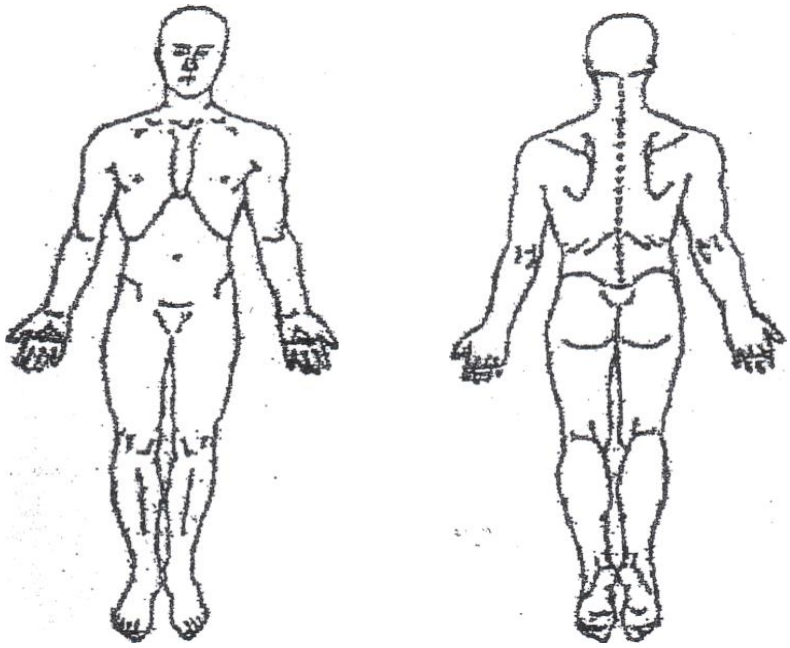
QUANTUM THERAPY, PC

Please indicate on the body chart the location of your symptoms by shading or marking.



Please rate the intensity of your symptoms on the scale below. Feel free to give a range of best to worst.

1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No Pain Worst Pain

In a few sentences, describe how activities, positions, or time of day affect your symptoms. What aggravates them? What relieves them? What gives you difficulty because of the symptoms? _____

_____

_____

_____

_____

_____

What are your goals for treatment?_____

_____

_____

_____

Patient Signature_____ Date_____