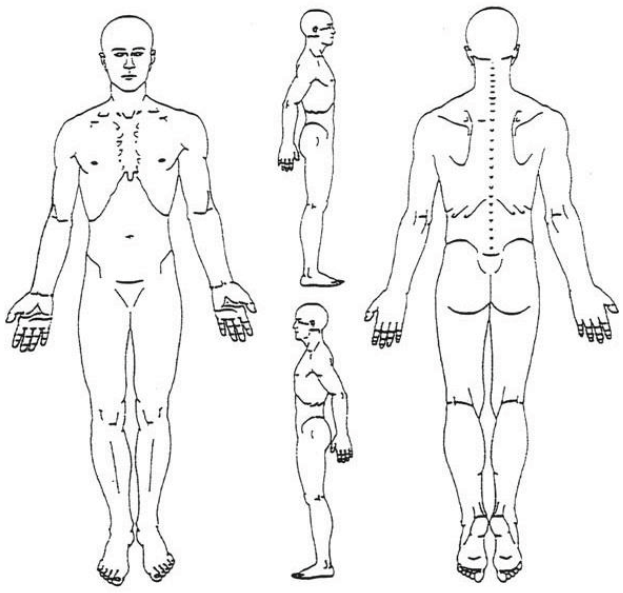

Location of Pain / Restriction / Other :

Onset: Initial (when/how it first began): .....

Now (current presentation): .....

Other Symptoms: .....

Type of Pain: .....

Referral of Pain: .....

What aggravates the pain?: .....

Degree of Pain 0-10: ..... Irritability Level: Low ..... Med ..... High .....

What offsets / alleviates the pain?: .....

.....

Past Treatments & Results: .....

.....

Special Questions (may also be specific to region): Night Pain? Dramatic Weight Loss/Gain .....

.....

.....

OBJECTIVE EXAMINATION:

Observation:

| Posterior View: | Anterior View: | Lateral View: |
|---|---|---|
| ..... | ..... | ..... |
| ..... | ..... | ..... |
| ..... | ..... | ..... |

**Motion Tests:**

| Active (P1, S1 or PB) | Passive (P1, S1 or R1) |
|---|---|
| Resisted (✓or ×) | Functional/Special Tests |

**Palpatory Assessment:**.....

.....

**Clinical Impression:** .....

**Patient Consent to Treatment: Please Sign:** ..... **Date:** .....

| **Treatment:** | **Reassessment:** |
|---|---|

**Corrective Exercises:**

| **Exercise** | **Sets** | **Reps** | **Other Advice** |
|---|---|---|---|
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |
| ..... | ..... | ..... | ..... |

**Postural Improvements:** .....

.....