M. STERS BACK & NECK
PAIN RELIEF CENTER

1010 South King Street, Suite 213
Honolulu, HI 96814
Phone: (808) 591-0099
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A. PATIENT INFORMATION

PATIENT: _____

DATE: _____

EMAIL: _____

Patient's Home Address

Phone **FAX**

Emergency Contact: _____

Phone Number: _____

Employer Business Address

Phone

Occupation

Social Security #

Referred By

Date Of Birth **Age**

Sex: ○ Male ○ Female

Marital Status:
○ Single
○ Married
○ Widowed
○ Divorced
○ Other

Patient Resides With:
○ Lives Alone ○ Spouse ○ Parents
○ Children ○ Other

Children:
○ Yes ○ No How Many? 1 2 3 4 5+

B. COMPLAINTS

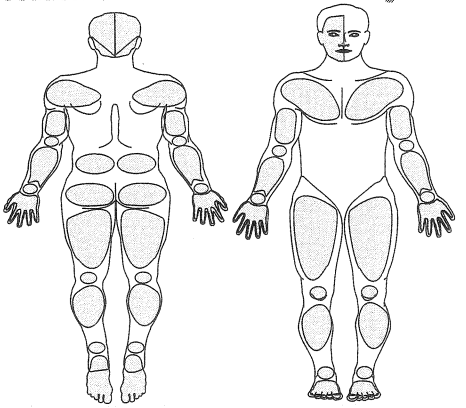
1. What Are Your Primary Complaints? ○ *None*

LEFT SIDE									RIGHT SIDE								
	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Head	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Neck	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Upper Back	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Mid Back	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Lower Back	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Shoulder	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Arm	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Forearm	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Wrist	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Hand	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Ribs	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Buttock	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Hip	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Thigh	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Leg	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Knee	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Ankle	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT
LEFT	(P)	(N)	(T)	(S)	(S)	(W)	(S)	Foot	(P)	(N)	(T)	(S)	(S)	(W)	(S)	RIGHT

If Your Symptoms Change, When Are They Worse

○ Morning ○ Evening ○ Afternoon
○ Night ○ Other_____

PAIN DIAGRAMS Please Mark The Location Of Your Pain On These Figures



3. Additional Complaints? ○ Yes ○ No Please List:

4. When Did Your Symptoms Begin?

○ Date

5. How Often Do Your Symptoms Occur?

○ Occasional ○ Intermittent ○ Frequent
○ Constant ○ Other

6. How Would You Rate Your Pain Today With 0 Being No Pain and 10 Being The Worst Pain?

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

No Pain — Worst Pain Possible