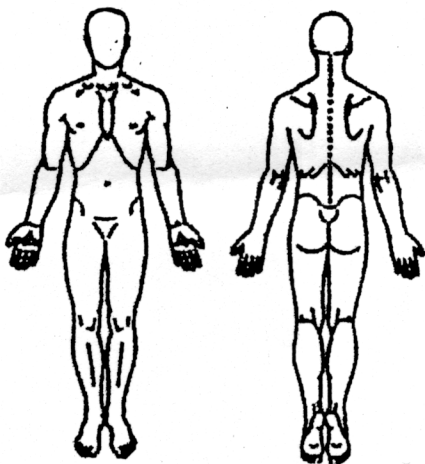


# Delta Village Chiropractic

Please indicate your areas of pain



Rate your severity of pain:

0 1 2 3 4 5 6 7 8 9 10  
(0 = no pain, 10 worst pain)

## GENERAL HEALTH

Activity Level	Low	Moderate	High	
Hours of sleep	0-4	4-6	6-8	8-10+
Do you drink coffee or colas?	Yes___	No___		
Do you smoke?	Yes___	No___		
Do you use recreational drugs?	Yes___	No___		
Do you take vitamin supplements?	Yes___	No___		
Alcohol Consumption	Low___	Med. ___	High___	
Do you wear foot orthotics?	Yes___	No___		