

NATUROPATHIC MUSCLE & JOINT CLINIC, LLC

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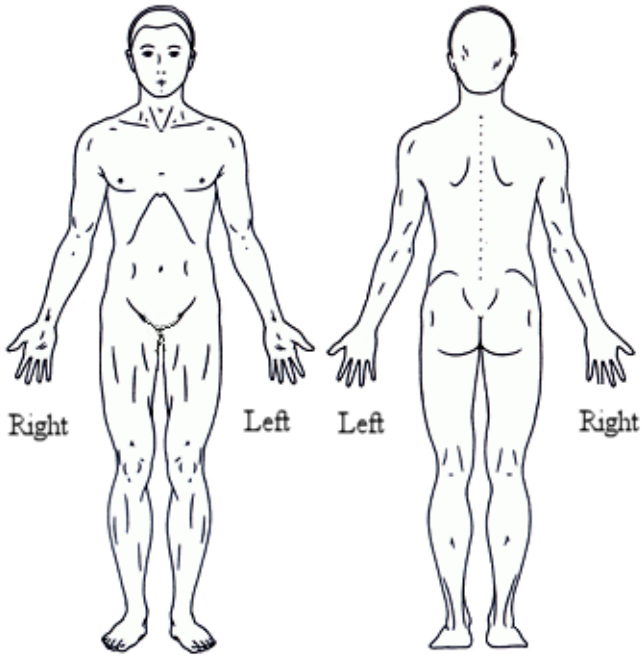
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Patient History

Name _____ Date _____

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness = = =

Dull Ache O O O

Burning X X X

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^