



8460 Holcomb Bridge Road
2nd Floor, Alpharetta, GA 30022

Pain and Stress Assessment

Please fill out completely.

Patient Name _____ DOB _____
Telephone (Cell) _____ (Work) _____ (Home) _____
Address _____ City _____ State _____ Zip _____
Occupation _____ # Hours Per Week Currently Working _____
Spouse's Occupation _____ # Hours Per Week Currently Working _____
Email _____

Please ONLY mark the main reason(s) you are here today. Circle primary complaint.

- Lower back pain
- Pain between shoulders
- Neck pain
- Joint shoulder pain
- Mid back pain
- Other _____
- Tension across top of shoulders
- Numbness/tingling in arms/hands
- Numbness/tingling in legs/feet
- Joint knee pain
- Headaches
- Achilles
- Nervousness
- Sleeping problems due to pain
- Hip/buttocks pain
- Joint elbow pain
- Fatigue
- TMJ

Which of the above is the worst problem? _____

How long have you had this problem (including off and on)? _____ years/months

At its worst, how bad is the pain from 1-10 (with one being no pain and ten being severe pain)? _____

Food and Chemical Sensitivity Questionnaire

Please mark any of the following symptoms that you have experienced in the past 60 days.

Digestive Symptoms	Sinus/Respiratory	Head/Ears	Emotional/Mental	Energy	Skin Disorders	Weight	Other Symptoms
Stomach pains or cramping	Stuffy or runny nose	Migraines	Depression	Fatigue	Eczema	Inability to lose weight	Joint pain
Constipation	Asthma	Headaches	Anxiety	Hyperactivity	Dermatitis	Food cravings	Arthritis
Diarrhea	Chest congestion	Earaches	Mood swings	Lethargy	Excessive sweating	Binge eating	Irregular heartbeat
Reflux or heartburn	Chronic cough	Ear infection	Irritability	Restlessness	Rashes	Water retention	Chest pains
Bloating	Wheezing	Ringling in ears	Poor concentration	Insomnia	Hives		Muscle aches
Gas	Frequent sneezing					Eyes/Throat	
Nausea or vomiting						Itchy eyes	
						Watery eyes	
						Sore throat	
						Persistent canker sores	