PATIENT INTRODUCTION FORM

☐**Update**

Patient Name:	**Today's Date:**
Address:	Telephone: □ home □ work □ cell
City/State/Zip:	Telephone: □ home □ work □ cell
Date Birth: / / Age: Sex: M / F	E-mail Address:
Height: Weight:	Social Security No:
Drivers License No:	Occupation:
Marital Status: □single □married □divorced □widowed	Employer's Name:
Spouse's Name: No. of Children:	Employer's Address:

Previous Chiropractic Care: ☐Yes ☐No Doctor's Name:_____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

_____

Referred by: Newpaper Television Website Existing Patient _____ Other _____

IS THIS VISIT RELATED TO A:

☐Work Related Injury ☐Car Crash Injury ☐Pedestrian Injury ☐Sports or Recreational Injury

☐Motorcycle-Bicycle Injury ☐Home Injury ☐Check-up Only ☐Other (Describe):_____

OTHER DOCTOR(S) SEEN FOR THIS CONDITION? (Circle all applicable) MD DC DO DDS PT

Doctor's Name _____ Diagnosis _____

X-rays _____ Urinalysis _____ Blood tests _____ Other _____

Treatment: Medication(s) _____ Physiotherapy _____

Results _____ Length of time under care _____

Were you off work? Yes No If yes, how long? _____

Have you had any other personal injury or accident? (Check all applicable) ☐Past year ☐Past 5 years ☐Over 5 years ☐None

AUTOMOBILE INSURANCE HEALTH INSURANCE INFORMATION

Health Insurance or Auto Insurance carrier	Name:
Insured person	Name: Date of Birth:
Relationship to the insured	Self Spouse Dependent Friend Third Party
What percentage does the insurance pay?	Percentage (%):
What is the insurance deductible per year?	Amount: $
Have you met the deductible this year	Yes No Partially $ Don't Know
Auto Insuarnce claim number	
Auto Insurance claim adjuster	Adjuster Name: Phone:
Auto Insurance carrier address	
Do you have an attorney representing you?	Attorney Name: Phone:
	Attorney Address:

You are ultimately responsible for any charges incurred in this office. Full payment is expected at the time of service. Our office will provide insurance billing services for you if you so desire as a courtesy. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

Signature of Responsible Party (Patient or Parent)_____ Date _____

Informed Consent

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands of a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the include, but not limited to, the following procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Muscle strength testing
- Postural analysis testing
- Ultrasound
- Hot/cold therapy
- EMS
- Basic Neurological testing

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow for formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Benjamin Su and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name	**Date**
Signature of Patient or Guardian	**Office Signature**

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Dr. Benjamin Su originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Dr. Benjamin Su is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Benjamin Su reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Benjamin Su change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

_____ _____

Signature of Patient/Guardian Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and refused as permitted.

[ ] Consent added to the patient's medical record on _____.

Patient Health History

Patient Name:_____ **Birth Date:** _____

Please check appropriate answer: (Please ask for help if you do not understand question)

□Yes □No Is your general health good? Name of your family Doctor:_____

□Yes □No Has there been a change in your health within the past three years? If Yes, why: _____

□Yes □No Have you been hospitalized or had a serious illness? If Yes, why:_____

□Yes □No Are you being treated by a physician now? For what? _____
Date of last medical exam: _____

□Yes □No Are you allergic to: drugs, foods, and medications? If Yes, what?_____

Have you experienced the following diseases or medical problems? ( )……translate in Chinese

□Yes □No Herpes 〈疱疹 〉

□Yes □No Anemia 〈貧血〉

□Yes □No AIDS or ARC 〈愛滋病〉

□Yes □No Fainting spells 〈暈眩〉

□Yes □No Skin diseases 〈皮膚病〉

□Yes □No Diabetes 〈糖尿病〉

□Yes □No Eye disease 〈眼疾〉

□Yes □No Dry mouth 〈口乾〉

□Yes □No Headaches 〈頭痛〉

□Yes □No Blurred vision 〈眼花〉

□Yes □No Jaundice 〈黃疸〉

□Yes □No Dizziness 〈頭暈〉

□Yes □No Surgeries 〈開刀〉

□Yes □No Frequent urination 〈頻尿〉

□Yes □No Psychiatric care 〈精神病治療〉

□Yes □No Sinus problem 〈鼻竇問題〉

□Yes □No Heart disease 〈心臟問題〉

□Yes □No Excessive thirst 〈極度口渴〉

□Yes □No Heart murmurs 〈心雜音〉

□Yes □No Rheumatic fever 〈風濕熱〉

□Yes □No Tumors, cancer 〈腫瘤，癌症〉

□Yes □No Recent weight lost, fever, night sweat
〈體重減輕，發燒，夜汗〉

□Yes □No Persistent cough, coughing up blood
〈咳嗽，咳血〉

□Yes □No Bleeding problem, bruising easily
〈流血問題，容易發瘀〉

□Yes □No Diarrhea, constipation, blood in stools
〈腹瀉，便秘，便血〉

□Yes □No Hepatitis, or other liver disease
〈肝炎，或其他肝病〉

□Yes □No Do you smoke cigarette, have tobacco
〈抽菸，雪茄〉

□Yes □No Swollen ankles 〈腳踝腫〉

□Yes □No Ringing in the ears 〈耳鳴〉

□Yes □No Seizures 〈癲癇，羊癲瘋〉

□Yes □No Artificial joint 〈人工關節〉

□Yes □No Chemotherapy 〈化學治療〉

□Yes □No Blood transfusions 〈換血〉

□Yes □No Pacemaker 〈心律調節器〉

□Yes □No Chest pain (angina) 〈胸痛，狹心病〉

□Yes □No Difficulty swallowing 〈吞食困難〉

□Yes □No High blood pressure 〈高血壓〉

□Yes □No Contact lenses 〈隱形眼鏡〉

□Yes □No Arthritis, rheumatism 〈風濕性關節炎〉

□Yes □No Shortness of breath 〈呼吸急促〉

□Yes □No Kidney, bladder disease 〈腎臟病〉

□Yes □No Frequent vomiting, nausea 〈嘔吐，噁心〉

□Yes □No Joint pain, stiffness 〈關節疼痛，僵硬〉

□Yes □No Thyroid, adrenal disease
〈甲狀腺，腎上腺病〉

□Yes □No VD(syphilis or gonorrhea)
〈性病，梅毒，淋病〉

□Yes □No Stomach problems, ulcers 〈胃病，潰瘍〉

□Yes □No Radiation treatments 〈放射性治療〉

□Yes □No Prosthetic heart valve 〈人工心臟瓣膜〉

□Yes □No Difficulty urinating, blood in urine
〈小便困難，尿血〉

□Yes □No Heart attack or defects
〈心臟病發作，心臟缺陷〉

□Yes □No Stroke, hardening of arteries
〈中風，血管硬化〉

□Yes □No TB, emphysema, other lung diseases
〈肺結核，肺氣腫，肺疾〉

□Yes □No Family history of diabetes, heart problems, tumors
〈家族有無糖尿，心臟，腫瘤之疾病〉

To the best of my knowledge, I have answered every question completely and accurately. I also understand that it is my responsibility to inform this office of any changes in my medical status, I hereby authorize the staff to perform the necessary services I / or my child may need.

Patient's /Parent's/Guardian's Signature_____ **Date** _____

Medical History Update
Date_____Comments_____Signature_____
Date_____Comments_____Signature_____

IMPORTANT: Please check (x) all present symptoms.

HEAD:

Headache

- ☐ Sinus (Allergy)
- ☐ Entire head
- ☐ Back of head
- ☐ Forehead
- ☐ Temples
- ☐ Migraine

☐ Head feels heavy
☐ Loss of memory
☐ Light-Headedness
☐ Fainting
☐ Eyes are sensitive to light
☐ Blurred vision
☐ Double vision
☐ Loss of vision
☐ Loss of taste
☐ Loss of balance
☐ Dizziness
☐ Loss of hearing
☐ Pain in ears
☐ Ringing in ears
☐ Buzzing in ears

NECK:

☐ Pain in neck
☐ Neck pain with movement
- ☐ Forward
- ☐ Backward
- ☐ Turn to left
- ☐ Turn to right
- ☐ Bend to left
- ☐ Bend to right

☐ Pinched nerve in neck
☐ Neck feels out of place
☐ Muscle spasms in neck
☐ Grinding sounds in neck
☐ Popping sounds in neck
☐ Arthritis in neck

ARMS AND HANDS:

☐ Pain in upper arm
☐ Pain in elbow
☐ Movement aggravated

☐ Tennis elbow
☐ Pain in forearm
☐ Pain in hands
☐ Pain in fingers
☐ Sensation of pins and needles in arms
☐ Sensation of pins and needles in fingers
☐ Numbness in arms (R-L)
☐ Fingers go to sleep
☐ Cold hands
☐ Swollen joints in fingers
☐ Sore joints in fingers
☐ Arthritis in fingers
☐ Loss of grip strength

SHOULDERS:

☐ Pain in shoulder joint (R-L)
☐ Pain across shoulders
☐ Bursitis (R-L)
☐ Arthritis (R-L)
☐ Can't raise arm
- ☐ above shoulder level
- ☐ over head

☐ Tension in shoulders
☐ Pinched nerve in shoulder (R-L)
☐ Muscle spasms in shoulders

MID-BACK:

☐ Mid-back pain
☐ Location _____
☐ Pain between shoulder blades
☐ Sharp stabbing
☐ Dull ache
☐ Pain from front to back
☐ Muscle spasms
☐ Pain in kidney area

CHEST:

☐ Chest pain
☐ Shortness of breath
☐ Pain around ribs
☐ Breast pain
☐ Dimpled or orange peel breast
☐ Irregular heartbeat

ABDOMEN:

☐ Nervous stomach
☐ Can't eat foods
☐ Nausea
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids

LOW-BACK:

☐ Low back pain
☐ Upper lumbar
☐ Lower lumbar
☐ Sacroiliac
☐ Low back pain is worse when:
- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing
- ☐ lying down (sleeping)
- ☐ walking

☐ Pain is relieved when _____
☐ Slipped disk
☐ Low back feels out of place
☐ Muscle spasms
☐ Arthritis

HIP, LEGS, AND FEET:

☐ Pain in buttocks
☐ Pain in hip joint
☐ Pain down leg
☐ Pain down both legs
☐ Knee pain
- ☐ inside
- ☐ outside

☐ Leg cramps
☐ Cramps in feet
☐ Pins and needles in legs
☐ Numbness of leg
☐ Numbness of toes

☐ Feet feel cold
☐ Swollen ankles
☐ Swollen feet

WOMEN ONLY:

☐ Menstrual pain _____(where)
☐ Cramping
☐ Irregularity
☐ Cycle _____ days
☐ Birth control _____type
☐ Hysterectomy
☐ Genital cancer _____
☐ Discharge
☐ Menopause
☐ Tumors
☐ Abortions
☐ Are you or do you think you are pregnant?

MEN ONLY:

☐ Urinary frequency _____
☐ Difficulty in starting
☐ Night urination
☐ Prostate pain/swelling

GENERAL:

☐ Nervousness
☐ Irritable
☐ Depressed
☐ Fatigue
☐ Generally feel run-down
☐ Normal sleep _____hrs/nt.
☐ Loss of sleep_____hrs/nt.
☐ Loss of wt. ___ lbs
☐ Gain weight ___lbs
☐ Coffee __cups/day
☐ Tea _____cups/day
☐ Cigarettes__pk(s)/dy
☐ Other _____
☐ Diabetes
☐ Hypoglycemia

Name: _____ Date: _____

Date of Birth: ____/____/____

CHECK RECENT OR CURRENT SYMPTOMS

Please indicate when you first noticed your symptom and how long you've had it.

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
☐ Headaches/Migraines		☐Upper Back Pain, Soreness or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, or Stiffness		☐ Leg/Foot Pain, Numbness or Tingling	
☐ Arm/Hand Pain, Numbness or Tingling		☐ Other:	
☐ Chest wall pain		☐ Other:	

WHAT SYMPTOM PRIMARILY BOTHERS YOU? _____

Please describe how the injury occurred. Date injury occurred: ____/____/____ _____

_____

_____

How bad is your pain? (Circle a #)	None	Mild Discomfort/Ache/Stiff			Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
Pain Level	0	1	2	3	4	5	6	7	8	9	10

Can you perform your daily living activities?	☐ Yes ☐ Yes, only with pain ☐ Not at all
How often are your symptoms present?	☐ Constantly ☐Frequently ☐ Occasionally ☐ Intermittently
Since it began, is your problem:	☐ Improving ☐Getting Worse ☐No Change
Can you perform your daily work activities?	☐Yes, all activities ☐Only Some ☐Not at all
Describe your stress level:	☐None to mild ☐Moderate ☐High
Do you exercise?	☐None to mild ☐Moderate ☐High

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describes how your symptoms currently feel to you.

Pain	Unbearable	Tight/Stiff	Miserable
Aches	Soreness	Radiating	Deep/Superficial Pain
Cutting	Pins and Needles	Weakness	Throbbing
Tearing	Irritating	Falls Asleep	Sharp/Stabbing
Crushing/Gripping	Nagging	Shooting	Tender
Pulling	Boring	Tingling	Heavy
Annoying	Burning	Dull	Other:_____

WHEN IS YOUR PAIN BETTER?

☐ Nothing	☐ Afternoon	☐ Evening
☐ Morning	☐ Lying Down Flat	☐ Standing
☐ During Sleep Hours	☐ Sitting	☐ Rest
☐ Walking	☐ Good Posture	☐ Exercise/Stretching
☐ Less Stress (mental)	☐ Movement	☐ Other:_____

WHEN IS YOUR PAIN WORSE?

☐ Nothing	☐ Afternoon	☐ Evening
☐ Morning	☐ Lying Down Flat	☐ Standing
☐ During Sleep Hours	☐ Sitting	☐ Rest
☐ Walking	☐ Good Posture	☐ Exercise/Stretching
☐ Less Stress (mental)	☐ Movement	☐ Other:_____

HAS YOUR PAIN BEEN ASSOCIATED WITH:

☐ Excessive Fatigue-malaise	☐ Bowel of Bladder Disorders
☐ Weight Loss	☐ Ovarian Pain
☐ Low Grade Fever	☐ Kidney Pain or Painful Urination
☐ Night Pain	☐ Night Sweats
☐ Abdominal Pain	☐ Balance Problems/Dizzy
☐ Nausea	☐ Tinnitus (Ringing in Ears)
☐ Vertigo (Room Spinning)	☐ Visual Disturbances

OTHER SYMPTOMS

If you have ever had in the past or present, please check below:

☐ Headache/Migraine	☐ Low back Pain/Soreness	☐ Upper/Middle Back Pain
☐ Neck Pain/Soreness/Stiffness	☐ Leg pain Rt / Lt	☐ Rib Cage Pain
☐ Shoulder Pain/Stiffness Rt / Lt	☐ Leg Numbness/Tingling Rt / Lt	☐ Hip Pain Rt / Lt
☐ Arm Pain/Tingling/Numbness Rt / Lt	☐ Pain Shoots Down Back of Leg Rt / Lt	☐ Knee Pain. Rt / Lt
☐ Wrist/Hand/Finger Pain/Numbness Rt/Lt	☐ Pain Primarily in Front of Thigh Rt/Lt	☐ Ankle/Foot Pain Rt / Lt
☐ Jaw Pain	☐ Weakness in Arms/Legs Rt / Lt	☐ Other:

PRIOR INJURY HISTORY

(☐ **I have no history of previous painful injury**.) If you have had prior injuries, please check below:

☐ Work Injury	☐ Fall	☐ Pedestrian Injury
☐ Lifting Injury	☐ Car Accident	☐ Military Injury
☐ Motorcycle Injury	☐ Bicycle Injury	☐ Sports Injury

FRACTURES/BROKEN BONES

(☐ **I have never had any broken bones**.) If you have broken any bones, indicate where and when:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar Bone (Clavicle)		☐ Rib Bone	
☐ Arm or Hand Bone		☐ Leg or Foot Bone	
☐ Pelvis Bone		☐ Other	

PREVIOUS SURGERIES

(☐ **I have never had any surgical procedure**.) If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck or back)		☐ Appendix	
☐ Disc surgery (neck or back)		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer	
☐ Tonsillectomy		☐ Rib/Collar Bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other:	

ARE YOU TAKING ANY MEDICATIONS?

(☐ **I am not currently taking any medications**.) Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Aspirin	☐ Diabetes Medication	☐ Cholesterol Medication
☐ Anti-inflammatory	☐ Tylenol	☐ Gabapentin (Nerve Blocker)	☐ Diuretic (Water Pill)
☐ Narcotics for Pain	☐ Advil/Motrin	☐ Blood Pressure Medication	☐ Stroke Prevention Meds
☐ Heart Medications	☐ Birth Control	☐ Antacid	☐ Other:

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

_____

Have you had X-rays, MRI, or other tests for this condition? What tests and when? _____

_____

TO ENHANCE YOUR QUALITY TIME WITH YOUR DOCTOR, PLEASE FILL OUT THE FOLLOWING ABOUT YOURSELF.

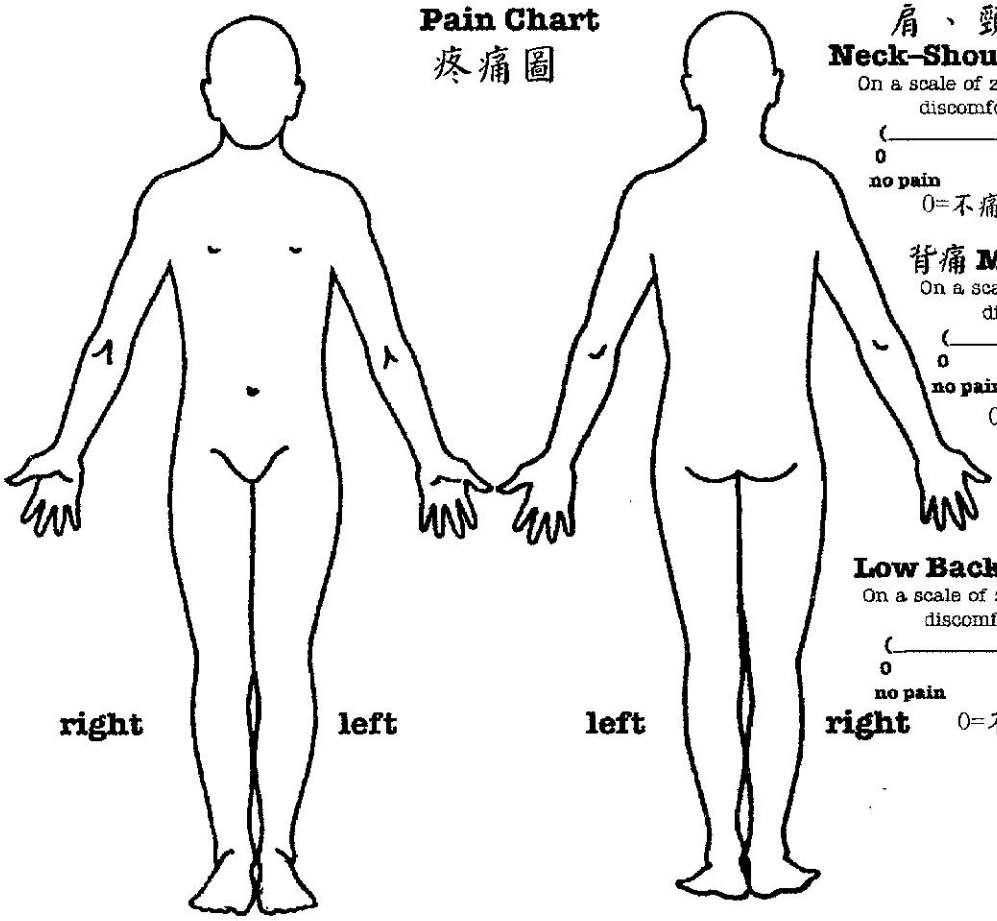
為了節省時間、請填這張表．謝謝！

Today I feel: Much Better Some Improvement Same Worse 1st time

今天我感覺： 好了很多 好一點 一樣 更不好 第一次

Pain Chart

疼痛圖



肩、頸、手痛

Neck–Shoulder–Arm Pain

On a scale of zero to 10, I rate my discomfort as follows:

0 10

no pain severe pain

0=不痛 10=非常痛

背痛 Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

0 10

no pain severe pain

0=不痛 10=非常痛

腰、腳痛

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

0 10

no pain severe pain

0=不痛 10=非常痛

Please Print Your Name:

請寫您的名字 _____

PAIN INTENSITY INSTRUCTION SHEET

PATIENT: Be certain to read the following pain categories and indicate which level best represents how severe your current pain level is. If you do not understand these instructions be sure to ask the Doctor.

Pain Intensity	None	**MILD**			**MODERATE**				**SEVERE**		
PAIN LEVEL	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

PAIN LEVEL AND THE EFFECT THAT PAIN HAS ON YOUR ABILITY TO PERFORM ACTIVITY	No Pain	Annoying Pain Level Only. Able to Perform All Home, Work, Sport, and Recreational Activities.	Pain Levels Now Cause You to Slow Down. You Are Able to Do Activities at Home and Work, But They Take You Longer to Do or You Need to Take Breaks. May be Unable to Very Demanding Activities.	Pain Levels Must Prohibit Your Ability to Perform Some Activities. You Must have Some Inability to Do Certain Activities. Must Have Some Difficulty Sleeping.
HOW DOES THE PAIN FEEL?	No Pain	Ache, Dull Soreness, Stiffness	Hurting Pain, Very Sore, Limited Motion	Sharp Pain, Stabbing Pain, Jabbing Pain
LEVEL	****	MILD	MODERATE	SEVERE

A LEVEL 10 PAIN IS EQUAL TO THE MOST SEVERE PAIN YOU HAVE EVER HAD!

A 10 level pain equates to having a baby pain or having the most severe toothache or kidney stone type of pain!

Form 3300