Dennis D. Knoche, D.C.
1010 S. Sunset
Roswell, NM 88203

PAIN DISABILITY QUESTIONAIRE

Name (Please Print) _____Date:_____

Age:_____Date of Birth:_____Occupation:_____

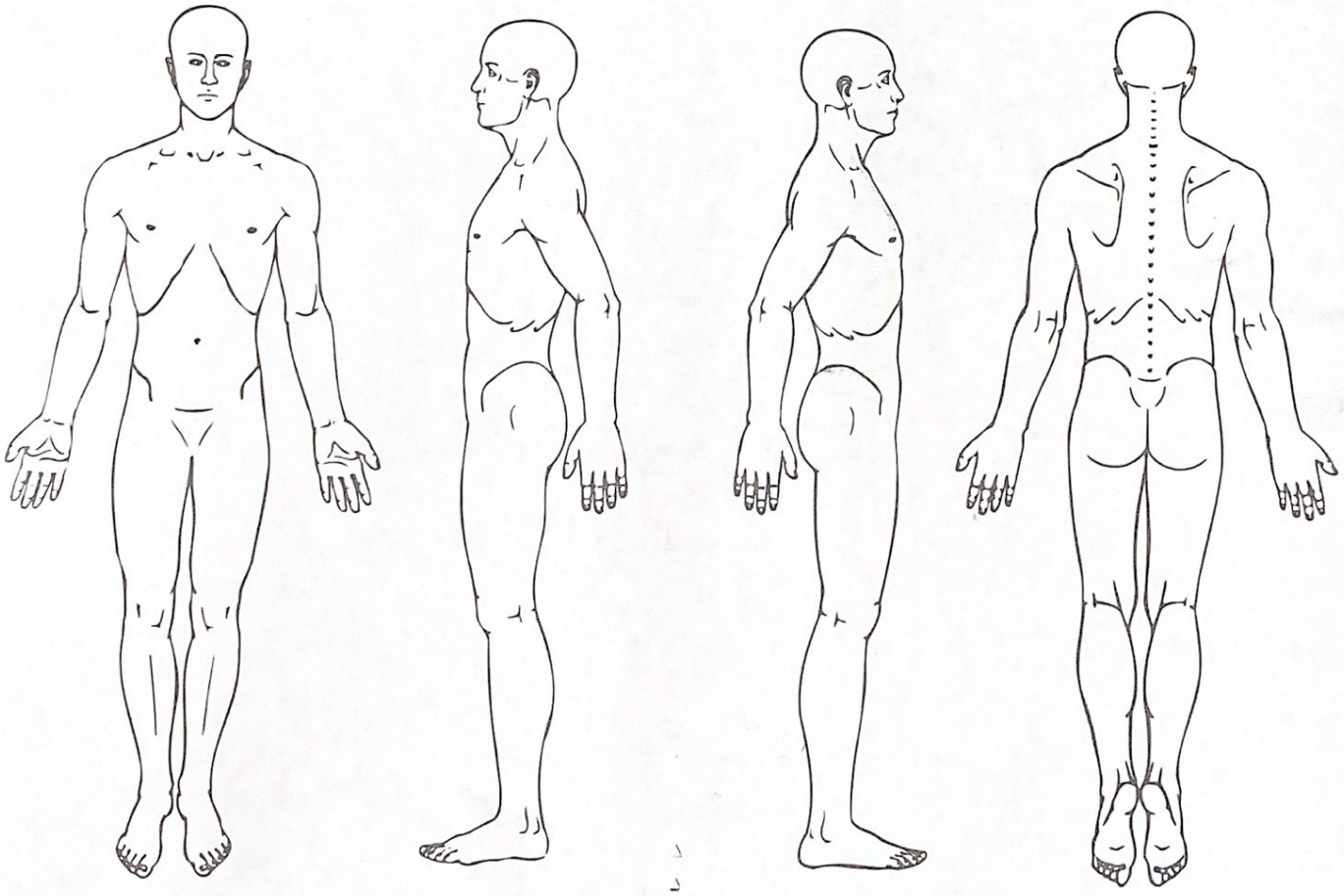
How long have you had these symptoms? ____Years ____Months____Weeks

Is this your first episode of these symptoms? ____ Yes ____ No

USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: A = ACHE B = BURNING N = NUMBNESS
P = PINS AND NEEDLES S = STABBING O = OTHER



OVER PLEASE