SPINE CHIROPRACTIC
REHABILITATION AND WELLNESS

Patient Name:_____ Date: _____

What is your primary concern/symptom?

_____

When did your symptom(s) begin? _____

Is your condition: Getting Worse / Getting Better / Unchanged?

Rate your current level of pain on a scale from 0 (No Pain) to 10 (Excruciating Pain):
0 1 2 3 4 5 6 7 8 9 10

Rate your pain level at its least: 0 1 2 3 4 5 6 7 8 9 10

Rate your pain level at its worst: 0 1 2 3 4 5 6 7 8 9 10

Have you experienced this problem before? Yes / No

When? _____

What makes this condition worse? _____

What makes it better? _____

How often do you have this pain? ☐ Constant ☐ Frequently (50-75% of the day)

☐ Occasionally (25-50% of the day) ☐ Intermittently (under 25% of the day)

Describe your complaint(s) below:	Mark the location of your complaint(s) above. Explain if needed: _____
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Tingling ☐ Aching	_____
☐ Shooting ☐ Burning ☐ Cramps ☐ Stiffness ☐ Swelling	_____
☐Other: _____	_____

Does your complaint move or radiate from one location to the other? Y/N

Does it hurt when you cough, sneeze, or bear down to go to the bathroom? Y/N

Have you seen another doctor for this condition? Y/N Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Treatment for this condition: _____

List all medications you take, including over the counter: _____

Vitamins/Supplements: _____

1166 Esplanade Ave Suite 2 Chico, CA 95926 - Phone: (530) 809 2695 Fax: (530) 645 1835
www.spinechico.com

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Check any of the following conditions you have had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/shoulder pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Earache
- ☐ Ear ringing
- ☐ Epilepsy
- ☐ Headaches
- ☐ Headaches - Migraine
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herniated disk
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Irregular cycle
- ☐ Kidney problems
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Osteoporosis
- ☐ Poor circulation
- ☐ Prostate problems
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus infection
- ☐ Stroke
- ☐ Thyroid problems
- ☐ TMJ
- ☐ Venereal disease
- ☐ Vertigo/Dizziness

Do you have, or have you had any other medical problems or diseases not covered above? Yes/No

Please List: _____

If Female, are you pregnant? Yes / No / Not Sure. Date of last menstrual period: _____

Have you had any: automobile accidents, other accident/injuries, surgeries, broken bones, and/or hospitalizations? Please explain and include dates: _____

_____

_____

Is there any additional information you would like the doctor to know before beginning care? _____

_____

Please mark areas of interest or if you desire more information:

- ☐ Postural Analysis/Training
- ☐ Therapeutic Exercises
- ☐ Orthotics
- ☐ Children's Chiropractic
- ☐ Nutritional Supplements
- ☐ Diet Analysis
- ☐ Weight Loss Information
- ☐ Massage
- ☐ Disc Decompression
- ☐ Traction
- ☐ Wellness Care
- ☐ Other: _____

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