

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:

Sharp Dull Throbbing Numbness Tingling Aching

Shooting Burning Cramps Stiffness Swelling

Other: _____

Mark the location of your complaint(s) above. Explain if needed: _____

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

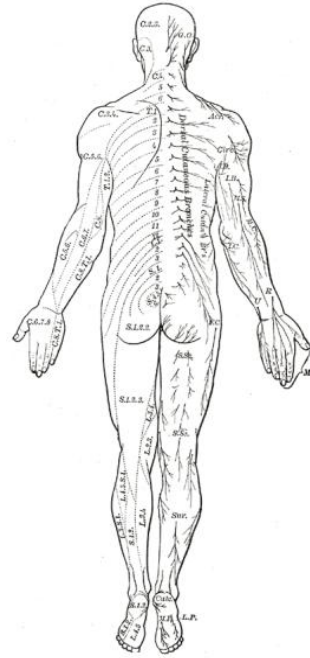
Have you seen another doctor for this condition? Y/N Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Treatment for this condition: _____

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

Vitamins/Supplements: _____





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Check any of the following conditions you have had:

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Postural Analysis/Training | <input type="checkbox"/> Nutritional Supplements | <input type="checkbox"/> Disc Decompression |
| <input type="checkbox"/> Therapeutic Exercises | <input type="checkbox"/> Diet Analysis | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Orthotics | <input type="checkbox"/> Weight Loss Information | <input type="checkbox"/> Wellness Care |
| <input type="checkbox"/> Children's Chiropractic | <input type="checkbox"/> Massage | <input type="checkbox"/> Other: _____ |