

PATIENT HISTORY

Last Name _____ First Name _____

Date of Birth _____ Social Security Number _____ - _____ - _____

Your Occupation _____

Have you ever been to another doctor for this problem? Y / N Who? _____

Have you been to a chiropractor in the last 3 years? Y / N

Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

PRIMARY COMPLAINT: _____

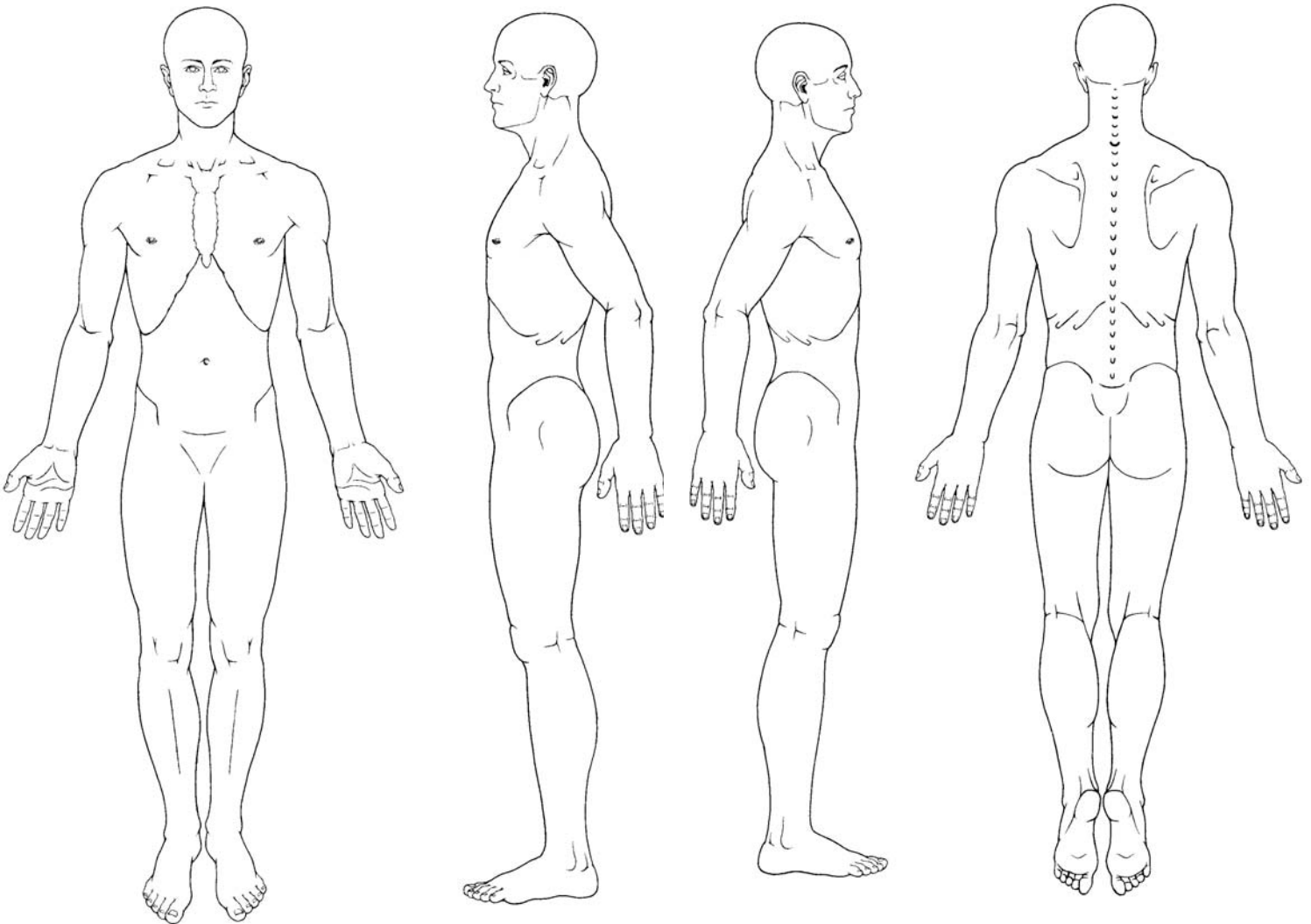
- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate anywhere? Y / N _____ Arm _____ Leg _____ Head
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ Daily _____ 1-2 x Week _____ 1-2 x Month _____ Constant _____ Other
- PAIN INTENSITY: Circle the intensity of your pain, on a scale 1-10... 10 being the worst.
_____ 1 2 3 4 5 6 7 8 9 10 _____

OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate anywhere? Y / N _____ Arm _____ Leg _____ Head
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ Daily _____ 1-2 x Week _____ 1-2 x Month _____ Constant _____ Other
- PAIN INTENSITY: Circle the intensity of your pain, on a scale 1-10... 10 being the worst.
_____ 1 2 3 4 5 6 7 8 9 10 _____

PATIENT SIGNATURE _____ DATE _____

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

- PPP Where you experience Pain
- NNN Where you experience Numbness
- TTT Where you experience Tingling
- BBB Where you experience Burning
- CCC Where you experience Cramp/Tension

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed _____

Name of Treating Physician _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed _____

Please list all past surgeries:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Please list all previous auto accidents, accidents and falls (even if sought NO treatments for it) :

What _____ When _____

What _____ When _____

What _____ When _____

What _____ When _____

Please list any medications or vitamins you are currently taking:

Other problem areas: check off... or make 'yes' or 'no'

Insomnia

Fatigue

Stress

TMJ

Shoulder Problems

Elbow / Elbow pain

Leg Problems

Knee Problems

Foot Problems

Disc Problems

Arthritis

Scoliosis

Any Immune Problems? Y / N

Any Eye, Ear, Nose, or Throat? Y / N

Any Heart Problems? Y / N

Any Lung Problems? Y / N

Any Breast Problems? Y / N

Any Urinary Problems? Y / N

Any Thyroid or Diabetes? Y / N

Any Mental – Emotional issues? Y / N

Any Allergies? Any Asthma? Y / N

List other conditions you think are relevant: _____

PATIENT SIGNATURE _____ DATE _____