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_____

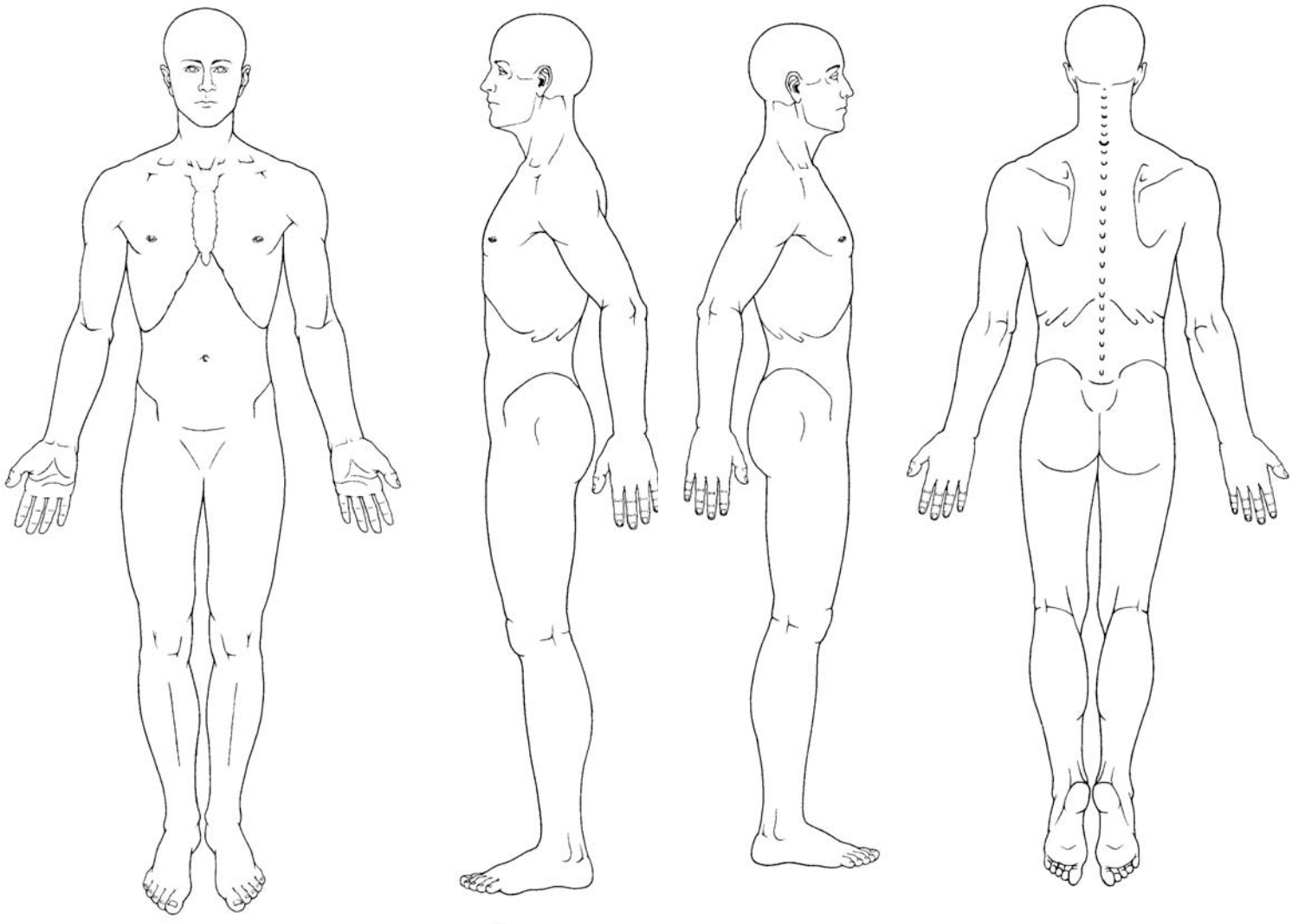
OTHER COMPLAINT: _____

- 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 _____