

Patient's Name _____ Birth Date _____ Age _____
 Occupation _____ Parent YES NO Ages of Children _____

CIRCLE AND COMPLETE ALL THAT APPLY AND ADD ANY COMMENTS

Daily tasks involve primarily (standing, sitting, lifting) explain _____

Symptoms: – low back pain – mid back pain – neck pain – headaches – migraines – carpal tunnel – foot pain

Please circle – health evaluation – any other concerns you wish to have addressed _____

Main reason/concern for today's visit _____

Date symptoms began: _____ Any numbness and tingling? Arms – fingers – thighs – legs _____

Referred pain: (example: neck shoulder arm; low back hip thigh leg) _____

Describe how condition started: lifting – fall – car accident – work injury – other _____

Rate your pain at its worst on a scale of 0-10 0=none, 10=worst _____ Rate your pain at its best on a scale of 0-10 0=none, 10=worst _____

Type of discomfort? Dull aches – tight/stiff – sharp pain with movement – shooting – burning _____

How often is your discomfort? daily percentage Constant 76-100% -- Frequent 51-75% -- Occasional 26-50% -- Intermittent 0-15%

In the past, how many episodes have you experienced 1-3, 4-7, none _____

What makes it worse? movement -- standing -- sitting -- bending/turning -- worse am or pm -- act of lying down

What makes it better? Standing -- sitting -- lying down – Medication -- rest -- activity -- ice -- heat – none

Have you had similar problems before or not at all? Including old injuries _____

Prior treatments/results; what/where? Chiropractic _____ drugs _____ surgery _____ physical therapy _____ none

Diagnostic tests/results: MRI -- CAT scan -- X-rays; Where were tests performed? _____ Last Physical exam? _____

Primary Care Physician M.D. _____ List all surgeries or hospitalizations or circle none _____

MEDICATIONS YOU ARE CURRENTLY TAKING, WHY, AND HOW LONG			LIST ALL VITAMINS/HERBS/MINERALS
Pain Meds	Muscle Relaxers	Antidepressants	Multivitamin or none
High Blood Pressure	Cholesterol	Diabetes	
Blood Thinner	Birth Control	Other or none	

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year. Circle left or right L or R		
HEADACHES <input type="checkbox"/> Occipital (back of head) <input type="checkbox"/> Frontal (front & sinus)	ARMS & HANDS <input type="checkbox"/> Pain in upper arm L R <input type="checkbox"/> Pain in elbow L R <input type="checkbox"/> Pain in forearm L R <input type="checkbox"/> Pain in hand/fingers L R <input type="checkbox"/> Pins & needles in arm L R <input type="checkbox"/> Pins & needles in fingers L R <input type="checkbox"/> Numbness in arm L R <input type="checkbox"/> Numbness in fingers L R <input type="checkbox"/> Weakness in arm L R <input type="checkbox"/> Weakness in Hand L R <input type="checkbox"/> Hands cold L R	HIPS, LEGS & FEET <input type="checkbox"/> Pain in buttocks L R <input type="checkbox"/> Pain in hip joint L R <input type="checkbox"/> Pain down leg L R <input type="checkbox"/> Numbness in leg L R <input type="checkbox"/> Pain in knee L R <input type="checkbox"/> Pain in ankle L R <input type="checkbox"/> Pain in foot L R <input type="checkbox"/> Weakness of leg L R <input type="checkbox"/> Weakness of knee L R <input type="checkbox"/> Leg cramps L R <input type="checkbox"/> Foot/Ankle sprain L R
NECK <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Can't turn head <input type="checkbox"/> Grinding/popping sounds	LOW BACK <input type="checkbox"/> Low back pain <input type="checkbox"/> Low back stiffness <input type="checkbox"/> Low back weakness <input type="checkbox"/> Pinched nerve in low back <input type="checkbox"/> Grinding/popping sounds <input type="checkbox"/> Muscle spasms - low back	<input type="checkbox"/> Any loss of control bowel/bladder <input type="checkbox"/> Any recent fever, weight loss/gain <input type="checkbox"/> Skin problems, cysts <input type="checkbox"/> Breathing, lung, allergies <input type="checkbox"/> Digestive, appetite, heartburn, constipation, diarrhea <input type="checkbox"/> Circulation, heart, stroke, fainting <input type="checkbox"/> Mood, depression, anxiety, sleep disturbance, nervous <input type="checkbox"/> Hormonal/Reproductive, urinary <input type="checkbox"/> Head, ear, nose, eyes, dizziness, vertigo, sinus <input type="checkbox"/> None Apply
SHOULDERS <input type="checkbox"/> Pain in shoulder joints L R <input type="checkbox"/> Can't raise arm L R <input type="checkbox"/> Above shoulder level <input type="checkbox"/> Over head <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Grinding/popping sounds		
MID BACK <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Muscle spasms - mid back		

Are your activities of daily living affected? YES NO

Are you able to work? YES NO Full-time Part-time Light-duty If out of work due to injury, how long? _____

How often do you use tobacco packs/day _____ alcohol drinks/day _____ drugs _____ caffeine coffee _____ tea _____ soda _____ per day

Do you have any other health concerns or problems we need to talk about? NO YES, _____

Are you on a restricted diet of any type or vegan? NO YES _____

What type of regular exercise do you perform? None Light Moderate Strenuous Describe _____

In general, would you say your health is Excellent Very good Good Fair Poor _____

Family Diseases-any cancer, diabetes, heart disease, stroke, arthritis, osteoporosis or other _____ parents, siblings

Females: Is there any chance you are pregnant at this time? NO YES Due date _____

I certify that the above information is correct to the best of my knowledge. _____

Patient's Signature

Date

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