



Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Are you a Parent (circle) YES NO Ages of your children \_\_\_\_\_

**CIRCLE AND COMPLETE ALL THAT APPLY AND ADD ANY COMMENTS**

Main reason for today's visit \_\_\_\_\_

Date symptoms began: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Describe how condition started: lifting – fall – car accident – work injury – other \_\_\_\_\_

Rate your pain on a scale of 0-10 (0=none-10=worst) \_\_\_\_\_

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

How often is your discomfort? (circle) Constant - Frequent – Occasional. How many episodes have you had? (circle) First time or Many

What makes it worse? movement -- standing -- sitting -- bending/turning -- act of lying down. Is it worse in the AM or PM?

What makes it better? Nothing – standing - sitting - lying down - rest - activity - ice - heat - medication \_\_\_\_\_

Prior treatments (date) Chiropractic \_\_\_\_\_ drugs \_\_\_\_\_ surgery \_\_\_\_\_ physical therapy \_\_\_\_\_ none

Diagnostic tests (circle) MRI - CAT scan - X-rays. Where/When were tests performed? \_\_\_\_\_

Primary Care Physician M.D. \_\_\_\_\_ Last Physical Exam: \_\_\_\_\_ date

List all surgeries or hospitalizations or circle **none** \_\_\_\_\_

MEDICATIONS YOU ARE CURRENTLY TAKING, WHY, AND HOW LONG (circle type and list)			VITAMINS/HERBS/MINERALS (circle and list)
Pain Meds	Muscle Relaxers	Antidepressants	NONE
High Blood Pressure	Cholesterol	Diabetes	Multivitamin
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 )		
<b>HEADACHES</b> <input type="radio"/> Occipital (back of head) <input type="radio"/> Frontal (front & sinus)	<b>ARMS &amp; HANDS</b> <input type="radio"/> Pain in upper arm L R <input type="radio"/> Pain in elbow L R <input type="radio"/> Pain in forearm L R <input type="radio"/> Pain in hand/fingers L R <input type="radio"/> Pins & needles in arm L R <input type="radio"/> Pins & needles in fingers L R <input type="radio"/> Numbness/Tingling in arm L R <input type="radio"/> Numb/Tingling in fingers L R <input type="radio"/> Weakness in arm L R <input type="radio"/> Weakness in Hand L R <input type="radio"/> Hands cold L R	<b>HIPS, LEGS &amp; FEET</b> <input type="radio"/> Pain in buttocks L R <input type="radio"/> Pain in hip joint L R <input type="radio"/> Pain down leg L R <input type="radio"/> Numbness in leg L R <input type="radio"/> Pain in knee L R <input type="radio"/> Pain in ankle L R <input type="radio"/> Pain in foot L R <input type="radio"/> Weakness of leg L R <input type="radio"/> Weakness of knee L R <input type="radio"/> Leg cramps L R <input type="radio"/> Foot/Ankle sprain L R
<b>NECK</b> <input type="radio"/> Pain in neck <input type="radio"/> Neck stiffness <input type="radio"/> "Head Feels Heavy" <input type="radio"/> Can't turn head - spasms <input type="radio"/> Grinding/popping sounds	<b>SHOULDERS</b> <input type="radio"/> Pain in shoulder joints L R <input type="radio"/> Can't raise arm L R <input type="radio"/> Above shoulder level <input type="radio"/> Pain in shoulder blade/collarbone <input type="radio"/> Tension in shoulders <input type="radio"/> Grinding/popping sounds	<b>CHECK and Circle ALL THAT APPLY or O None Apply</b> <input type="radio"/> Any recent fever, weight loss/gain <input type="radio"/> Skin problems, cysts <input type="radio"/> Breathing, lung, allergies <input type="radio"/> Digestive, appetite, heartburn, constipation, diarrhea <input type="radio"/> Circulation, heart, stroke, fainting <input type="radio"/> Mood, depression, anxiety, sleep disturbance, nervous <input type="radio"/> Hormonal/Reproductive, urinary <input type="radio"/> Head, ear, nose, eyes, dizziness, vertigo, sinus <input type="radio"/> Any loss of control bowel/bladder
<b>MID BACK</b> <input type="radio"/> Mid-back pain <input type="radio"/> Mid-back stiffness <input type="radio"/> Pain between shoulder blades <input type="radio"/> Muscle spasms - mid back	<b>LOW BACK</b> <input type="radio"/> Low back pain <input type="radio"/> Low back stiffness <input type="radio"/> Low back weakness <input type="radio"/> Pinched nerve in low back <input type="radio"/> Grinding/popping sounds <input type="radio"/> Muscle spasms - low back	

Are your activities of daily living affected?  YES  NO (list) \_\_\_\_\_

Daily tasks involve primarily (standing, sitting, lifting) explain \_\_\_\_\_

Are you able to work?  YES  NO Full-time/ Part-time/Light-duty \_\_\_\_\_

How often do you use tobacco \_\_\_\_\_ packs/day OR alcohol \_\_\_\_\_ drinks/day OR drugs OR caffeine (coffee/tea/soda) \_\_\_\_\_ per day

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 \_\_\_\_\_

Would you say your health is Excellent Very Good Good Fair Poor. Any other major diagnoses: \_\_\_\_\_

Family Diseases: cancer, diabetes, heart disease, stroke, arthritis, osteoporosis, 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