

Name: _____ Date: _____

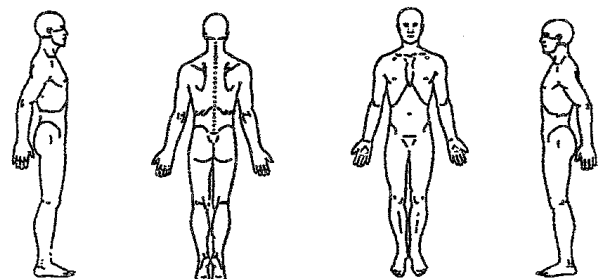
PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below please describe the present complaint(s) that brought you to this clinic for chiropractic care. The information you provide concerning the past and present symptoms assist your doctor in obtaining an early understanding of your state of health.

- 1. Present Complaint: _____
- 2. Please describe the character of your current pain (you may check one or more answers): Sharp/Stabbing Sharp/Dull Aches Dull
 Soreness Weakness Throbbing/Gnawing Numbness Shooting Gripping/Constricting Burning Tingling
- 3. How often are the complaints present? Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)
- 4. How bad is your pain or ache? Please check a number: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN UNBEARABLE
- 5. Since your problem began the pain is: Increasing Decreasing Not Changing
- 6. Did your problem begin: Immediately after a specific accident Multiple incidents Gradually developed over time
- 7. When did your problem begin? (list specific date if possible): _____
- 8. Describe how your problem began: _____
- 9. What treatment have you received for this present condition? None Therapy from PT A back support Surgery Spinal injections
Other: _____
- 10. Were you previously treated for a different occurrence of this same condition? Yes No If yes, by: Chiropractor MD Therapy
Other: _____ Specify dates and type of treatment: _____
- 11. What makes your problem better? Nothing Laying down Walking Standing Movement/Exercise Inactivity
Other: _____
- 12. What makes your problem worse? Nothing Laying down Walking Standing Movement/Exercise Inactivity
Other: _____
- 13. How would you grade your stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed
- 14. Physical activity at work: Sedentary (More than 50% of Workday) Light Manual Labor Manual Labor Heavy Manual Labor
- 15. General physical activity: No Regular Exercise Program Light Exercise program Strenuous Exercise Program
- 16. Are your complaints affecting your ability to work or otherwise be active? No effect Some physical restrictions (able to do light duty tasks)
 Need limited assistance with common everyday tasks Need assistance often Have a significant inability to function without assistance
 Am totally disabled (impaired)/Cannot care for self

Mark an X on the picture where you continue to have symptoms—including pain, numbness, tingling etc.

Do you want further information/or have additional questions regarding:

Any suggestions how we can improve our service to you and to others:



Patient's Signature: _____ Date: _____