**Patient Name**______________________________ **Date**____________________________

## Symptoms

Primary Complaint_________________________ Problem Started On____________________

Pains are: ❑Sharp ❑Dull ❑Throbbing ❑Aching ❑Numb ❑Shooting
❑Burning ❑Tingling ❑Cramping ❑Stiffness ❑Swelling ❑Other__________

Rate the severity of your pain. (1 mild symptoms to 10 severe pain): 1 2 3 4 5 6 7 8 9 10

Is this condition getting progressively worse? ❑Yes ❑No

Is the pain constant or does it come and go?_______________ How often do you have it?__________

Does it interfere with your ❑Work ❑Sleep ❑Daily routine ❑Recreation

Activities that are difficult to perform:
❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying Down Other____________________

What activities lessen your condition/pain? ____________________________________________

What treatment have you already received for this condition? ❑Medication ❑Physical Therapy ❑Surgery
❑Chiropractic ❑None ❑Other_____________________________________________

Name of Doctors who treated you for this condition____________________________________

Rate the priority level of your desire to *correct* this problem. (1, low – 10, high) 1 2 3 4 5 6 7 8 9 10

OTHER SYMPTOMS:

| | | | |
|---|---|---|---|
| ❑Headaches | ❑Pins & Needles in Legs | ❑Loss of Balance | ❑Diarrhea/Constipation |
| ❑Neck Pain | ❑Pins and Needles in Arms | ❑Loss of Memory | ❑Stomach/Heartburn |
| ❑Upper Back Pain | ❑Numbness in Fingers | ❑Irritability | ❑Menstrual complaints |
| ❑Mid Back Pain | ❑Numbness in Toes | ❑Tension | ❑Heart complaints |
| ❑Low Back Pain | ❑Cold Feet | ❑Nervousness | ❑Breathing/Asthma |
| ❑Hip Pain | ❑Cold Hands | ❑Fatigue | ❑Dizziness/Fainting |
| ❑Leg Pain | ❑Ears Ringing/Buzzing | ❑Depression | ❑Shoulder Pain |

(Women) Are you Pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth control? ❑Yes ❑No

## Daily Habits

| | | | | |
|---|---|---|---|---|
| Exercise: | ❑None | ❑Moderate | ❑Daily | ❑Heavy |
| Work Habits: | ❑Sitting | ❑Standing | ❑Light Labor | ❑Heavy Labor |
| Sleep Position: | ❑Side | ❑Stomach | ❑Back | |
| Do You Smoke? | ❑Yes | ❑No | Packs/Day__________ | |
| Do You Have High Stress? | ❑Yes | ❑No | Reason____________ | |

What Vitamins/Nutritional Supplements do you take?_____________________________________

What Medications are you taking?___________________________________________________

*Choose Wellness.*

## Health History

Injuries/Surgeries you have had Date

Falls______________________________ ________

Head Injuries______________________________ ________

Broken Bones______________________________ ________

Dislocations______________________________ ________

Surgeries______________________________ ________

Auto Accidents______________________________ ________

Other______________________________ ________

Please list other health conditions: ______________________________

______________________________________________

______________________________________________

Is there a family history of:

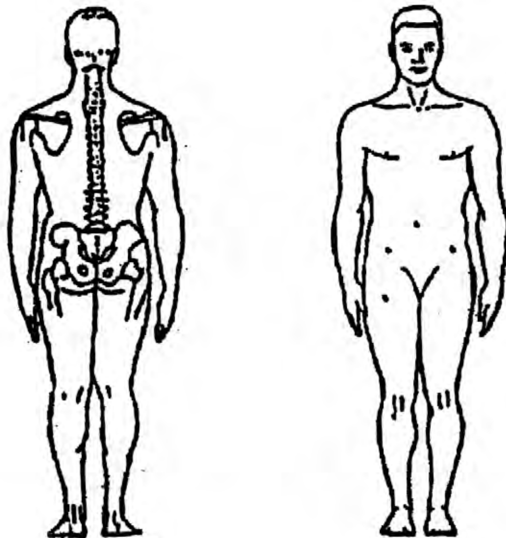
| | | | | |
|---|---|---|---|---|
| Mother's side | ❑ Heart Disease | ❑ Arthritis | ❑ Cancer | ❑ Diabetes |
| Father's side | ❑ Heart Disease | ❑ Arthritis | ❑ Cancer | ❑ Diabetes |

When you were a child:

Did you have a difficult birth process? ❑Yes ❑No ❑Caesarian ❑Breach ❑Forceps

Did you fall or have other traumas? ❑Yes ❑No

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off and on, when standing, when sitting, etc..



I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature______________________________ Date______________________