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Legal Name:_____ Preferred Name: _____ Date:_____

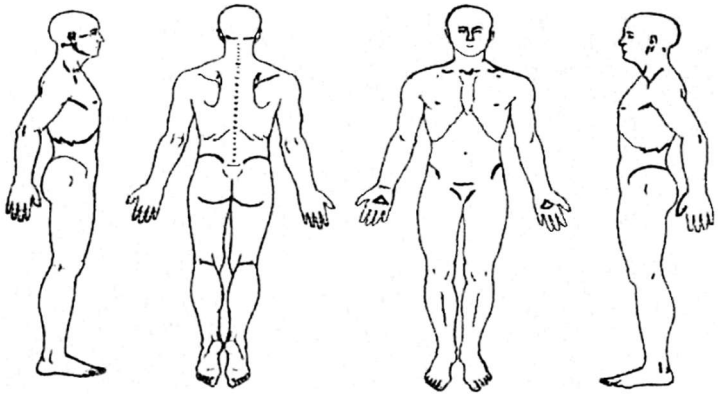
Circle the Severity of Pain (0= No Pain to 10= Very Severe Pain) AND Frequency of Pain (% of the week you experience the pain)

Condition/ Problem/ Complaint	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
A _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
B _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
C _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Use the conditions/ problems/ complaints chart above and circle **all that apply** to the coordinating letter

A is:	Sharp	Dull	Burning	Aching	Numbness	Tingling	Pins & Needles	Tightness	Stiffness
B is:	Sharp	Dull	Burning	Aching	Numbness	Tingling	Pins & Needles	Tightness	Stiffness
C is:	Sharp	Dull	Burning	Aching	Numbness	Tingling	Pins & Needles	Tightness	Stiffness

PLEASE MARK THE FIGURES WHERE YOU EXPERIENCE PAIN (with circles or X's)



Symptoms are **WORSE** in the (circle what applies)

Morning	Increase during the day
Afternoon	Same all day
Night	Decrease during the day

How did your symptoms begin: _____

When did your symptoms begin: _____ Have you experienced this before? YES / NO

Do your symptoms radiate: YES / NO If yes (circle one): Arms Legs Head

Has your condition (circle one): Improved Gotten Worse Stayed the Same

Since it began, **CIRCLE** the activities that make your problems worse:

Bending	Walking	Twisting	Sitting	Running	Looking over Shoulder	Falling Asleep	Driving a Car
Lying	Standing	Movement	Lifting	Concentrating	Rising out of a Chair or Bed	Staying Asleep	Other:

Is there anything you can do the relieve the problems? YES / NO If yes, provide details:_____

If NO, what have you tried that hasn't helped:_____

→

Have you been treated for this before: YES / NO If yes, how long ago: _____

What treatment did you receive: Chiropractic Medical Physical Therapy Massage Other_____

Results of previous treatment: GOOD / POOR Additional comments_____

Were you referred to our office by anyone, who:_____

Is this condition interfering with WORK SLEEP DAILY ROUTINES RECREATION OTHER_____

Family Physician: _____ May we send your health information to this provider: YES / NO

Emergency Contact (Name, Relationship, Phone Number):_____

Have you ever been under chiropractic care: YES / NO If so, who/ when: _____

Have you had any spinal x-rays, MRI's, or CT's taken in the past three years: YES / NO If so, when/ where _____

_____

Any serious illnesses: _____ When:_____

Do you have a pacemaker: YES / NO

What medications are you taking:

Pain Killers	Muscle Relaxers	Cholesterol Medications	Other_____
Insulin	Birth Control	Blood Pressure Medication	Other_____

Please circle to indicate whether you have had any of the following:

Alcoholism	Blood Pressure **High/Low**	Depression/Anxiety
Diabetes	Strokes	Heart Disease
Epilepsy	Headaches	Lung Issues
Goiter	Liver Disease	Pancreatitis
Kidney/Bladder Disease	Multiple Sclerosis	Rheumatoid Arthritis
Parkinson's Disease	Prostate Problems	Ulcers
Spinal Stenosis **Neck/Low Back**	Thyroid **Hypo/Hyper**	GI Issues/Stomach
Metal Implants	Fractures	Cancer
Location:	**Type:**	**Types:**
Other_____	Other_____	Other_____

Please circle to indicate whether you have had any of the following surgeries:

Gallbladder	Hernia	Hip **LEFT / RIGHT**	**JOINT REPLACEMENT**
Appendectomy	Hysterectomy **PARTIAL / TOTAL**	Knee **LEFT / RIGHT**	Shoulder **LEFT / RIGHT**
Heart	Rotator Cuff **LEFT / RIGHT**	Foot **LEFT / RIGHT**	Knee **LEFT / RIGHT**
Abdomen	Carpel Tunnel **LEFT / RIGHT**	Herniated Disc **NECK / LOW BACK**	Hip **LEFT / RIGHT**
			Other_____

I certify that the above information is accurate to the best of my knowledge

Patient Signature (or guardian): _____ Date: _____