PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

Please Rate Your Symptoms
(1-10, with 1 being the least serious)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT
WHEN AND HOW OCCURRED?_____
_____
SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE
❑GRADUAL ONSET ❑SUDDEN ONSET DATE OCCURRED_____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?
_____ _____

HAVE YOU EVER HAD CHIROPRACTIC CARE? ❑NO ❑YES DOCTORS NAME_____
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____
ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____
DATE OF LAST PHYSICAL_____ DATE OF LAST SPINAL X-RAY_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *AGGRAVATE* YOUR CONDITION:

❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING
❑TURNING HEAD ❑TURNING IN BED ❑LIFTING ❑SNEEZING ❑WALKING
❑LYING DOWN ❑STANDING ❑DRIVING ❑GETTING UP FROM A SEAT
❑OTHER_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *RELIEVE* YOUR CONDITION:

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING
❑WALKING ❑APPLYING HEAT ❑APPLYING COLD ❑STRETCHING ❑EXERCISE ❑TAKING MEDICINE
❑OTHER_____

PLEASE CHECK ANY *ADDITIONAL SYMPTOMS* YOU MAY BE EXPERIENCING:

❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss / confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed
❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia
❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds
❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms
❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset
❑other_____

I authorization the release of information necessary to file insurance claims and to assign my medical benefits to Dr. James M. Stites. I am ultimately responsible for all charges incured at Imagine Chiropractic and that my insurance is being billed as a courtesy.

Patient Signature:_____Date:_____