History of the Chief Complaint

BELMONT chiropractic

Patient Name (Last, First)	*Date*

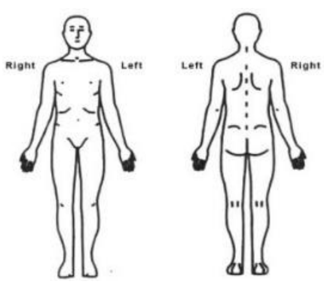
Chief Complaint

Please describe your reason for today's visit

What caused your symptoms to first occur?

When did your symptoms first appear?

Please mark all regions where you have symptoms occurring:



Question	Yes	No
Have you experienced any traumas/accidents?	□	□
Do your symptoms interfere with daily life/work?	□	□
Have you experienced these symptoms in the past?	□	□
Have you seen other physicians for these symptoms?	□	□
Are you experiencing any tingling/numbness?	□	□
Does your pain radiate to a different region?	□	□

How intense are your symptoms today?
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (least to most intense)

How intense are your symptoms at their worst?
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (least to most intense)

How would you describe your symptoms *(Please check all that apply)*?
□ Dull/Achy □ Sore/Tender □ Burning □ Other ___________________
□ Stiff/Tight □ Sharp/Stabbing □ Tingling/Numb □ Other ___________________

What, if anything, helps alleviate your symptoms *(Please check all that apply)*?
□ Heat □ Ice □ Stretching/Exercise □ OTC medicine □ Prescription medicine
□ Nothing has worked □ Nothing has been tried □ Chiropractic □ Massage

What, if anything, makes your symptoms worsen?

Do you notice that your symptoms worsen during a specific time of day?
□ First wake up □ Mid-day □ Afternoon □ Evening □ Night-time/during sleep
□ Other

Patient Signature

Patient / Parent / Guardian Signature	*Date of Signature*

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