

1. The symptom(s) that have prompted me to seek care today include: _____

Patient name _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?) _____

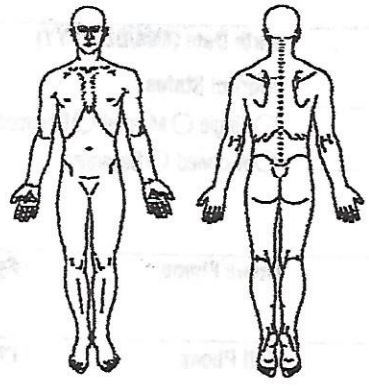
4. Intensity (How extreme are your current symptoms?)
 ○○○○○○○○○○○○○○○○○○○○○
 Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)
 Circle the area(s) on the illustration.
 "O" for current condition
 "X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
 What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Dr. Allain know about your current condition? _____

12. How does your current condition interfere with your:
 Work or career: _____
 Recreational activities: _____
 Household responsibilities: _____
 Personal relationships: _____

13. Review of Systems
 Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

| | | | | | | |
|--|--|--|--|--|--|----------------------------|
| a. Musculoskeletal | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | Initials _____ |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |
| b. Neurological | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and needles | <input type="radio"/> Numbness | Initials _____ |
| c. Cardiovascular | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive bruising | Initials _____ |
| d. Respiratory | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breath | <input type="radio"/> Pneumonia | Initials _____ |
| e. Digestive | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | Initials _____ |
| f. Sensory | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infection | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | Initials _____ |
| g. Integumentary | | | | | | |
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Eczema | <input type="radio"/> Acne | <input type="radio"/> Hair loss | <input type="radio"/> Rash | Initials _____ |

Consultation Notes

Doctor's Initials _____

Allain Chiropractic Clinic
Dr. Ladd Allain