Account # _____

Name:_____ Date: _____ DOB: _____/_____/_____

Current height: _____ Current weight: _____

Complaints

1. Please describe your primary complaint: _____
2. When did your primary problem start? _____
3. What caused your primary problem (e.g. injury, lifting.)? _____
   _____
4. Do you have any other secondary complaints? □ No □ Yes Please explain: _____
   _____

Please rate your symptoms on a scale from 0-10 where 0 is no pain and 10 is unbearable pain.

(please rate the pain at the current moment even if it fluctuates)

Example: Area: Lower back - 7/10

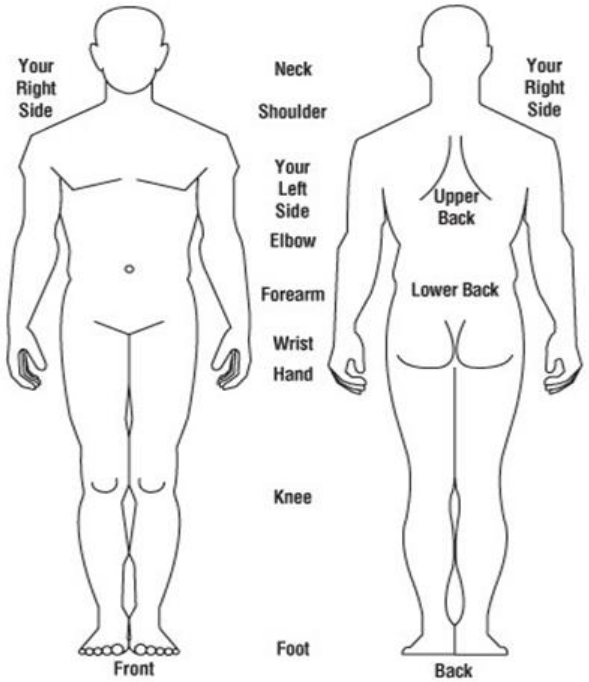
Area: _____ - _____/10 Area: _____ - _____/10

Area: _____ - _____/10 Area: _____ - _____/10

Area: _____ - _____/10 Area: _____ - _____/10

Please use the symbols below to draw on the body where you feel your symptoms.

A=Ache B=Burning N=Numbness T=Tingle P= Pins/Needles o=Other _____



Account#_____

Name:_____ Date: _____ DOB: _____/_____/_____

5. How often is your pain present? Write your complaints next to the frequency that fits the best.
   Constant (present 76-100%)_____
   Frequent (present 51-75%)_____
   Occasional (present 26-50%)_____
   Intermittent (present 0-25%)_____

6. Does your pain radiate to your arms or legs? ☐ No ☐ Yes If yes, where?_____

7. What time of day is your pain its worst? ☐ AM ☐ Afternoon ☐ PM
8. What position(s) or activities increase your pain?_____
   _____
9. What position(s) or activities decrease your pain?_____
   _____
10. Are you taking any prescription or over the counter medication for your complaints? ☐ No ☐ Yes. If yes what meds? _____
11. What home treatment have you tried (eg, ice, heat, exercises) for your condition? _____
    _____
12. Is your condition worse with coughing, sneezing or straining with bowel movements? ☐ No ☐ Yes (explain): _____
13. Are you losing control of bladder or bowel function? ☐ No ☐ Yes (if yes please explain: _____
    _____
14. Any recent illness? ☐ No ☐ Yes explain: _____
15. Do you suffer from severe fatigue? ☐ No ☐ yes (explain):_____
16. Have you suffered weight loss of over 10 pounds without trying? ☐ No ☐ Yes
17. Do you suffer from chills or night sweats? ☐ No ☐ Yes
18. Have you seen any other health care providers for your problem(s)? ☐ No ☐ Yes
    If yes, who? _____
    Treatment?_____
19. What are you here for? ☐ Pain relief ☐ Pain relief and corrective care
20. Have you ever had chiropractic care in the past? ☐ No ☐ Yes (if yes when was last treatment) _____

Patient (or legal guardian) signature X_____ Date X_____