Miracles Health Care Center

TOTAL BODY RELEASE CHIROPRACTIC CARE

Your Present State of Health / Ill Health

Present /Current Complaint: _____

_____

When did you first notice this complaint? _____

How would you describe the pain? *(check any that apply)*

☐ SHARP	☐ DULL	☐ DEEP	☐ SUPERFICIAL
☐ BURNING	☐ SHOOTING	☐ STABBING	☐ TINGLING
☐ NUMBNESS	☐ CONSTANT	☐ EPISODIC	☐ INTERMITTENT

☐ OTHER (describe) _____

Level of Pain: (Please circle the number that best describes your level of pain)

0 1 2 None 3 4 5 6 7 Moderate 8 9 10 Extreme Pain

Does the pain travel into either your arms or legs? ☐ Yes ☐ No ☐ Arms ☐ Legs

If yes, how far down the arm or leg does it travel? _____

Does anything make it worse? _____

Does anything make it better? _____

Is there a time of day that it is worse? _____

Is the condition getting progressively worse? _____

Have you seen other professionals for this condition? _____

Are there any home remedies that you find helpful? _____

Are you taking any over-the-counter medications for this? _____

Describe any other related symptoms that you have in connection to this condition, (ie. digestion, and/or bowel activity?)_____

_____

Are you currently under medical care? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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