

**Chief Complaint/Problem:**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE #: \_\_\_\_\_

What is your current health problem or complaint? \_\_\_\_\_

Date symptoms started: \_\_\_\_\_ When did you first seek treatment for this problem? \_\_\_\_\_

Have you seen other doctors for this condition?  Y  N Have you had this or similar conditions in the past?  Y  N

How long has this episode lasted? \_\_\_\_\_

What is the location of your pain? \_\_\_\_\_

Does the pain radiate to another area of your body?  Y  N \_\_\_\_\_

Symptoms getting worse?  Y  N  Same What makes this condition worse? \_\_\_\_\_

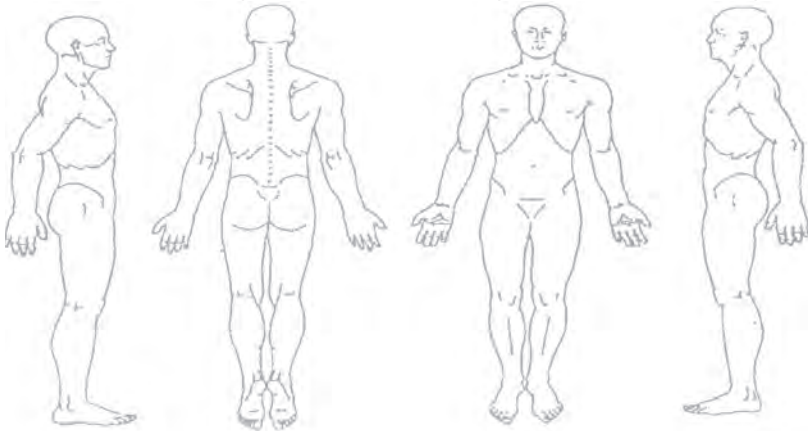
What relieves this condition? \_\_\_\_\_

Pain interferes with  Sleep  Daily living  Work  Recreation

Please rate the pain relating to your current condition using the following scale: (0=No Pain thru 10=Worst Pain)

	0	1	2	3	4	5	6	7	8	9	10
Current pain intensity:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Average pain intensity:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worst pain intensity:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please use the legend symbols below to accurately mark the areas in which you feel the above described sensations



- Stabbing/Cutting - **XXX**
- Burning - **BBB**
- Numbness - **NNN**
- Tingling (pins & needles) - **•••**
- Cramping - **CCC**
- Dull - **DDD**

Have you seen a chiropractic before?  Y  N

Have you had x-rays taken of the following:  Back  Neck  Chest  Other Date of last x-ray \_\_\_\_\_

Have you been treated for any other health condition(s) in the past year?  Y  N

If so, please identify: \_\_\_\_\_

What is your health philosophy? (What do you need to do to be healthy?) \_\_\_\_\_

How do you want us to handle this problem? \_\_\_\_\_

- Temporary Relief (help with symptoms but do not fix the cause of the problem)
- Maximum correction/wellness (correct cause of problem for maximum stability in the future.)

On a scale of 1 to 10 (10 being the most and 1 being the least)

- \_\_\_\_\_ How committed are you to being at your maximum health potential?
- \_\_\_\_\_ How important is it for your family to be at their optimum health potential?
- \_\_\_\_\_ How committed are you to preventing illness and maximizing your spinal and muscular stability?

*I hereby state that the above information is true and correct to the best of my knowledge:*

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Spouse's or Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_