Name_____ **Date**_____

Please circle or place an "X" where pain is located. Only one complaint per diagram please.

Current Complaint (the reason you are here)

1)	**2)**
When did it start?	**When did it start?**
How did it happen?	**How did it happen?**
How often does it occur? Constantly Frequently Occasionally Intermittently	**How often does it occur?** Constantly Frequently Occasionally Intermittently
Describe the pain (Circle all that apply) Sharp Shooting Dull Ache Tight Burning Stiff Numb/ Tingle Sharp w/ motion Other:	**Describe the pain** (Circle all that apply) Sharp Shooting Dull Ache Tight Burning Stiff Numb /Tingle Sharp w/ motion Other:
Does it radiate? If so, where?	**Does it radiate?** If so, where?
Since it began, has it improved stayed the same gotten worse	**Since it began, has it** improved stayed the same gotten worse
Pain rating 0 1 2 3 4 5 6 7 8 9 10	**Pain rating** 0 1 2 3 4 5 6 7 8 9 10
Symptoms relieved by	**Symptoms relieved by**
Symptoms aggravated by	**Symptoms aggravated by**
Has this occurred in the past Y N	**Has this occurred in the past** Y N
Have you seen anyone else for this:	**Have you seen anyone else for this:**
Name:	Name:
Name:	Name:
Any other recent tests x-ray MRI CT lab	**Any other recent tests** x-ray MRI CT lab
What do you have difficulty performing due to this? __ bending over __ getting in/out of car __ rising from chair/bed __ care of family __ getting to sleep __ showering/bathing __ climbing stairs __ staying asleep __ sitting __ concentrating __ grocery shopping __ standing __ dressing self __ household chores __ using a computer __ driving car __ lifting __ walking __ exercising __looking over shoulder __ yard work __ lying down __ reaching overhead	**What do you have difficulty performing due to this?** __ bending over __ getting in/out of car __ rising from chair/bed __ care of family __ getting to sleep __ showering/bathing __ climbing stairs __ staying asleep __ sitting __ concentrating __ grocery shopping __ standing __ dressing self __ household chores __ using a computer __ driving car __ lifting __ walking __ exercising __looking over shoulder __ yard work __ lying down __ reaching overhead
Any additional concerns/complaints?	**Any additional concerns/complaints?**

What is your: Height_____ Weight _____ Occupation_____

How would you rate your overall Health? Excellent Very good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Does mother(M), father (F), sisters (S) or brothers (B) have any of the following:
Arthritis M F S B Diabetes M F S B Hypertension M F S B Heart disease M F S B
Cancer M F S B

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
___	___	Headaches	___	___	High blood pressure	___	___	Diabetes
___	___	Neck pain	___	___	Heart attack	___	___	Excessive Thirst
___	___	Upper Back pain	___	___	Chest pains	___	___	Frequent urination
___	___	Mid back pain	___	___	Stroke	___	___	Smoking/Tobacco use
___	___	Low back pain	___	___	Angina	___	___	Drug/Alcohol Depend
___	___	Shoulder pain	___	___	Kidney stones	___	___	Allergies
___	___	Elbow/upper arm pain	___	___	Kidney disorders	___	___	Depression
___	___	Wrist pain	___	___	Bladder infection	___	___	Systemic Lupus
___	___	Hand pain	___	___	Painful urination	___	___	Epilepsy
___	___	Hip pain	___	___	Loss of bladder control	___	___	Dermatitis/Eczema
___	___	Upper leg pain	___	___	Prostate problems	___	___	HIV/AIDS
___	___	Knee pain	___	___	Abnormal Wt Gain/Loss			
___	___	Ankle/foot pain	___	___	Loss of appetite	**Females Only**		
___	___	Jaw pain	___	___	Abdominal pain	___	___	Oral Contraceptives
___	___	Joint pain/stiffness	___	___	Ulcer	___	___	Irregular periods
___	___	Arthritis	___	___	Hepatitis	___	___	Menstrual cramps
___	___	Rheumatoid arthritis	___	___	Liver/gall bladder disorder	___	___	Pregnancy
___	___	Cancer	___	___	General fatigue	___ pregnancies		___ live births
___	___	Tumor	___	___	Muscular incoordination	___	___	Menopause
___	___	Asthma	___	___	Visual disturbances	___	___	Hot flashes
___	___	Chronic sinusitis	___	___	Dizziness	___	___	HRT

List all prescription and OTC medications you are currently taking: _____
_____

List any vitamins or supplements you are currently taking: _____
_____

List all surgical procedures you have had: _____

What activities do you do outside of work? _____

Have you ever been hospitalized? Y N If yes, why? _____

Have you ever seen a Chiropractor? Y N Name _____ When_____

Have you had significant past trauma? Y N If yes, describe _____

Anything else pertinent to your visit today? _____

Patient Signature_____