

DATE: _____

ACCT: _____

PATIENT: _____

PATIENT HISTORY

1. What is your main complaint? _____

2. On the scale below, please circle the **severity** of your main complaint (At it's worst)

None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

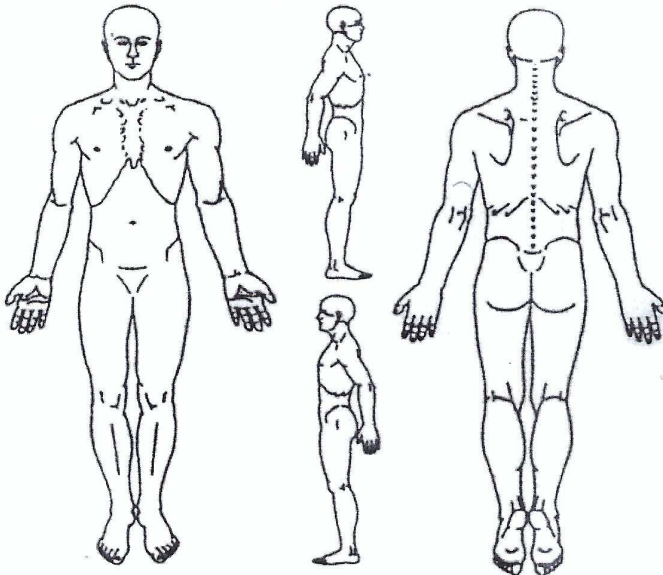
3. On the scale below please circle the **percentage of time** you experience your main complaint:

Occasional			Intermittent			Frequent			Constant		
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your main complaint? _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache B: burning pain C: cramping D: dull pain R: throbbing pain N: numbness T: tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

- personal care _____
- lifting _____
- reading _____
- concentrating _____
- work _____
- driving _____
- sleeping _____
- recreation _____
- walking _____
- sitting _____
- standing _____
- social life _____

6. When do you notice it most? AM PM

How long does it last? _____ Mins _____ Hrs

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? Yes No

10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider never received care for this problem.

11. Have you lost time from work because of it? Yes No
Dates? _____ to _____

12. Are you Pregnant? Yes No

13. What was the first day of your last menstrual cycle? _____

14. Number of pregnancies? _____ Miscarriages? _____

Signature: _____

Date: ___/___/___ 4