

## PATIENT HISTORY

Chief Complaint : \_\_\_\_\_ When did it start? \_\_\_\_\_

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10
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Mild

Severe

Has the pain ever been a level 9 or 10?  Yes  No

When do you feel it most?  AM  PM When present, how long does the complaint last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

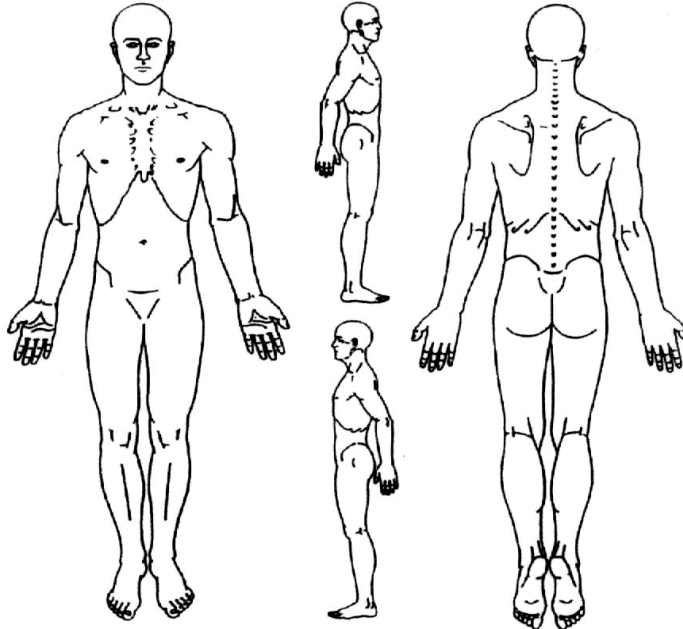
*Note: If you need additional sheets, please ask the front desk.*

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100
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Using the letters below, please show **where** you are experiencing **all** of your current complaints:

- A: Ache
- B: Burning
- C: Cramping
- D: Dull Pain
- F: Stiffness
- N: Numbness
- R: Throbbing
- S: Soreness
- T: Tingling
- X: Sharp Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

- Walking Y N
- Standing Y N
- Running Y N
- Sleeping Y N
- Driving Y N
- Personal Grooming Y N
- Sitting Y N
- Kneeling Y N
- Exercising Y N
- Bending Y N
- Lifting Objects Y N
- Lifting Children Y N
- Housework Y N

1. Have you ever had the condition(s) in the past?  Yes  No If yes, please indicate what sort of treatment have you ever had:  Hospitalization  Chiropractic care  Medical doctor / Specialty provider  None
2. Have you ever lost work due to your condition(s)?  Yes  No If Yes, dates? \_\_\_\_\_
3. Are you pregnant?  Yes  No Number of pregnancies? \_\_\_\_\_ Number of miscarriages? \_\_\_\_\_
4. What was the first day of your last menstrual cycle? \_\_\_\_\_

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low			Medium				High			
0	1	2	3	4	5	6	7	8	9	10

Patient Name (please print): \_\_\_\_\_ Account # \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.