

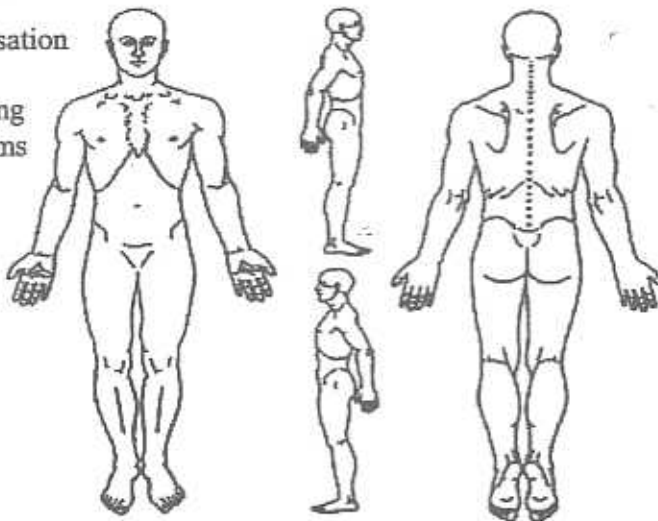
PATIENT HISTORY

I am allergic to: _____

1. What is your chief complaint? _____
2. When did this problem first begin? _____
3. What do you feel causes your problem to occur? _____
4. Are you currently experiencing any pain or symptoms? Yes No
5. On the diagram below please show where you are experiencing pain or symptoms related to your complaint.

Use the letters to represent what type of pain.

- A. Aching
- B. Burning sensation
- C. Cramping
- D. Dull throbbing
- M. Muscle spasms
- N. Numbness
- S. Sharp
- T. Tingling



6. How long have you been in pain? Days ____ Wks ____ Mns ____ Yrs ____
7. When do you notice it most? _____
8. What makes it feel better? _____
9. What makes it feel worse? _____
10. Have you ever had this problem in the past? Yes No
How Often? _____ When was the last time? _____
11. I have been - Hospitalized Treated by another chiropractor
 Treated by another specialty provider
 Never received care for this problem
12. Have you lost time from work because of it? Yes No
Dates _____ to _____
13. Are you pregnant? Yes No
14. What was the first day of your last menstrual cycle? _____
15. Number of pregnancies? _____ Miscarriages? _____
16. What other problems do you have that you feel may be related to your primary presenting problem? _____
17. Does any member of your family suffer from the same or similar problem(s)? Yes No
18. What are your hobbies? _____

FOR DOCTOR'S USE ONLY

Area/Muscular _____

- Acute Exacerbation
 - Sudden Onset
 - Progressive w/o obv cause
- Relationship(s) to Factors:

- Referred Unrelated
- Constant Intermittent

System(s):

- Severity:
- Mild
 - Moderate
 - Moderately Severe

Episodic Presentation:
A ____ SA ____ Chronic ____

- Symptom Status:
- Task Related _____
 - Decreasing Since _____
 - Increasing _____

Effects:

Social _____
Work _____
Personal _____

Childhood:

No. Episodes X ____ NA
 Persistent Recurrent
 NL Duration _____

Neuro: _____
Musculo: _____
Relationship: _____
