Patient: _____ Date: _____

Patient History

1. What is your **main complaint**? _____

2. On the scale below, please **circle** the **severity** of your **main complaint** (at its worst)

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

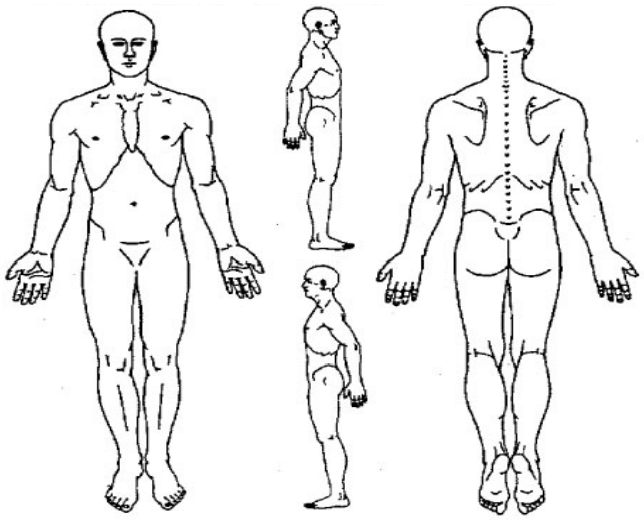
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**

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

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

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 **N:** numbness **R:** throbbing pain **S:** sharp **T:** tingling



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. Is your sleep disturbed due to pain? □ Yes □ No
12. Have you lost time from work because of it? □ Yes □ No Dates: _____ to _____
13. How much have your symptoms interfered with your usual daily activities? (*including both work outside the home and housework*) □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
14. How is your condition changing, since care began at *this* facility?
    □ N/A – This is the initial visit □ Much worse □ Worse □ A little worse □ No change □ A little better □ Better □ Much better
15. How has this condition affected/changed your lifestyle?

_____

_____