

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)

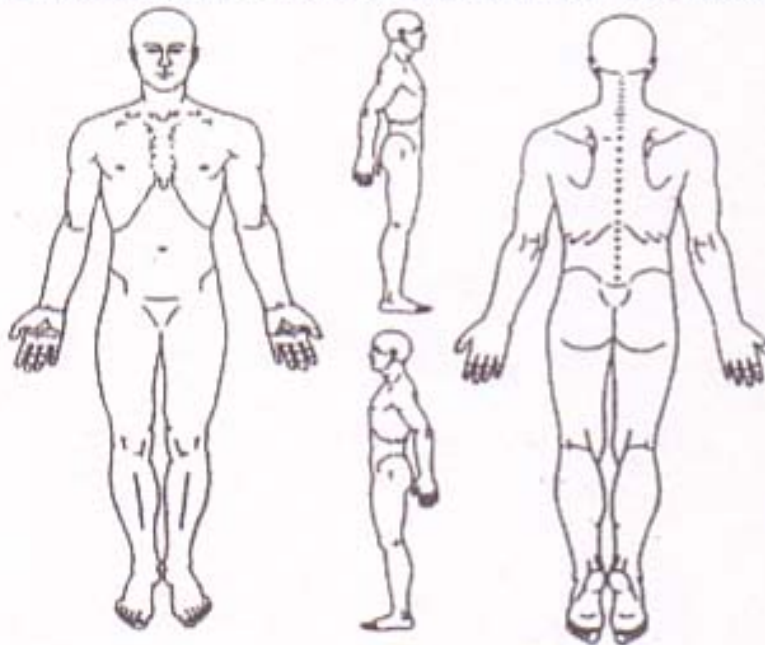
None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

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 _____

Signature: _____

Date: ____ / ____ / ____

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? _____