



# Information about your current condition/complaints

What is your primary complaint/problem? \_\_\_\_\_

List other symptoms: \_\_\_\_\_

When did your symptoms first begin (give date if possible)? \_\_\_\_\_

How did your symptoms first begin? \_\_\_\_\_

Pain is:  Constant  Intermittent

Is your condition getting worse? \_\_\_\_\_

What activities aggravate your condition? (list) \_\_\_\_\_

What activities lessen your symptoms? (list) \_\_\_\_\_

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Have you had:  Xray  MRI or CAT Scan  EMG  Bone Scan  Blood Work

Who is your family medical doctor: \_\_\_\_\_

List all home remedies tried for this problem: \_\_\_\_\_

Is your condition worse at certain times of the day or night? \_\_\_\_\_

Does your condition interfere with: (yes/no) work \_\_\_\_\_ sleep \_\_\_\_\_ normal daily routine \_\_\_\_\_

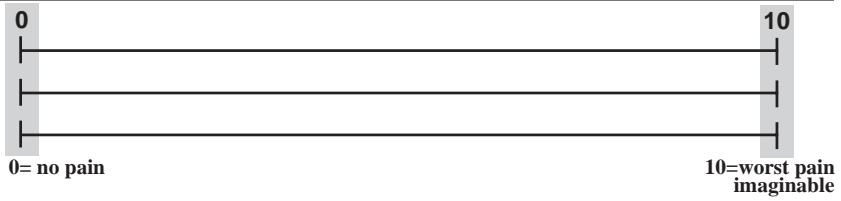
Have you had symptoms like this before?  no  yes (describe) \_\_\_\_\_

*Regarding your main complaint:*

1. RIGHT NOW:

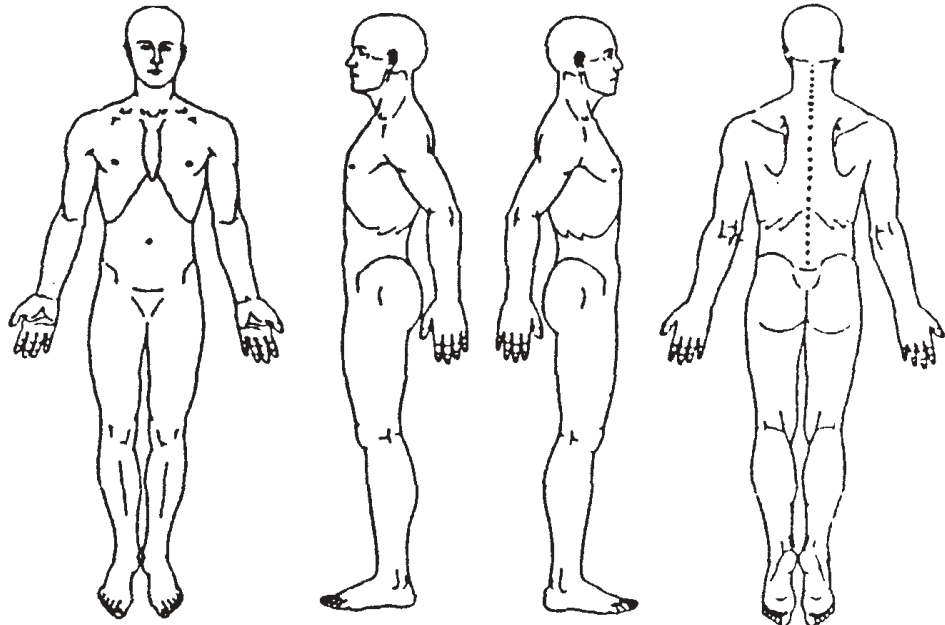
2. AVERAGE:

3. AT WORST:



Draw the area of your symptoms using these symbols:  
(mark on the figures)

- XXX = ache
- \* = sharp/stab
- ooo = numb/tingle
- = shooting
- //// = stiff/tight



**NOTICE TO NEW PATIENTS:** Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

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