

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_

1. Primary Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,Onset of Symptoms\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How did symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How often do you feel symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Average pain intensity: Last 24 hours: 0 1 2 3 4 5 6 7 8 9 10 Worst pain

 Past Week: 0 1 2 3 4 5 6 7 8 9 10 Worst pain

1. How often do you experience your symptoms? Constantly (76-100% of the time)

 Frequently (51-75% of the time), Occasionally (26-50% if the time), Intermittently (0-25% of the time)

1. How much has your symptoms interfered with your usual daily activities?

 \_\_Not at all \_\_A little bit \_\_Moderately \_\_Quite a bit \_\_Extremely

1. Since onset of symptoms have you experienced any of the following (check all that apply):

 \_\_Difficulty w/bowel or bladder control \_\_Fever or Chills \_\_Numbness

\_\_Unexplained Weight Loss \_\_Vision or Hearing issues \_\_Numbness in Genital/Anal Area

\_\_Dizziness or Fainting \_\_Weakness \_\_Other \_\_\_\_\_\_\_\_\_\_\_

1. Have you been treated of this condition before? \_\_Yes \_\_No

 (if yes) \_\_MD \_\_PT \_\_Chiropractor Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had diagnositics/test for your current condition?

\_\_ None \_\_X-Ray \_\_MRI \_\_CT Scan \_\_Bone Scan \_\_EMG/NCV

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Description of pain (circle all that apply)**

|  |  |  |
| --- | --- | --- |
| Dull Ache | Burning | Cramping |
| Deep Ache | Throbbing | Soreness |
| Sharp | Nagging | Numbness |
| Shooting | Squeezing | Tingling |
| Electrical | Zinging | Radiating |
| Stabbing | Twinge |  |



1. What makes it worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What makes it better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***PLEASE COMPLETE QUESTIONS ON THE BACK***

1. In general, would you say your overall health right now is…

\_\_Excellent \_\_Very good \_\_Good \_\_Fair \_\_Poor

1. Do you now have, or have you ever had, any of the following?

Diabetes Yes/No Prior Surgery Yes/No

High Blood Pressure Yes/No Are you Pregnant Yes/No

Pacemaker Yes/No Metal Implants Yes/No

Circulatory Disease Yes/No Cancer Yes/No

Kidney Problems Yes/No Osteoporosis Yes/No

Respiratory Problems Yes/No Grind Teeth Yes/No

Epilepsy Yes/No Dizziness Yes/No

Broken Bones Yes/No Recent Weight Loss Yes/No

Bowel/Bladder Issues Yes/No Chronic Pain Yes/No

Pins/Needles/Numbness Yes/No Frequent Stress Yes/No

Chronic Headaches Yes/No STD Yes/No

Hepatitis A, B, or C Yes/No MRSA Yes/No

Arthritis Yes/No MS Yes/No

Parkinson’s Yes/No Thyroid Yes/No

ALS/Lou Gehrig’s Yes/No Lupus Yes/No

Degenerative Joint Disease Yes/No

1. List any surgeries and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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1. List any prescribed medications and what they are for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List any over the counter medication or vitamin supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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