Confidential Patient Data

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Patient Name: _____ Date: _____

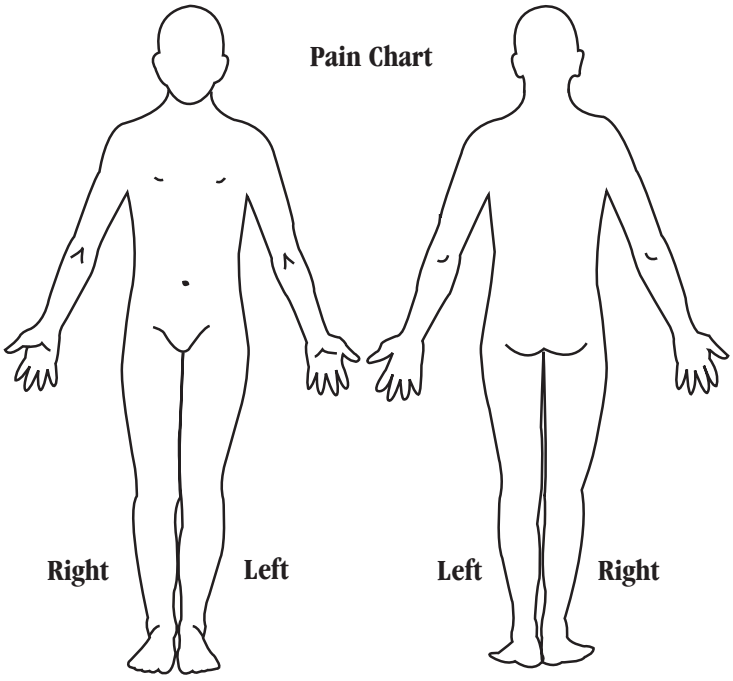
Please Rate your symptoms 1-10, with 1 being least serious and 10 being most serious.

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Using the symbols below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Numbness	Pins and Needles	Burning	Aching	Stabbing
----	0000	xxxxx	*****	/////
----	0000	xxxxx	*****	/////
----	0000	xxxxx	*****	/////

Pain Chart



Neck-Shoulder-Arm Pain

On a scale of zero to ten, I rate my discomfort as follows

(————————————)
0 10
no pain severe pain

Mid Back Pain

(————————————)
0 10
no pain severe pain

Low Back and Leg Pain

(————————————)
0 10
no pain severe pain

Previous Chiropractic Care: ❑ Y ❑ N Name: _____ Date: _____

Is Your Condition: ❑ Acute/Sudden ❑ Chronic/Recurrent

Symptoms Are Worse In: ❑ Morning ❑ Afternoon ❑ Night ❑ Activity

When and How Occurred? _____

_____

Symptoms Developed From: ❑ Job Related Injury ❑ Auto Accident ❑ Other ❑ Accident

❑ Illness ❑ Unknown Cause ❑ Gradual Onset Date Occurred: _____

Symptoms have persisted for # ____Hour(s) ____Day(s) ____Week(s) ____Month(s) ____Year(s)

Symptoms/Complaints: ❑ Come & Go ❑ Are Constant

Have you ever dad this before? ❑ No ❑ Yes

When? _____

If you were to guess, what do you think is causing your complaints?

_____

Name and location of Doctors previously seen for present condition(s):

_____

Are you allergic to any medications? ❑ No ❑ Yes What kind? _____

Are you taking any medications? ❑ No ❑ Yes What kind? _____

Are you pregnant? ❑ No ❑ Yes Date of last menstrual period? _____

Please check the following activities that aggravate your condition: ❑ Bending ❑ Reaching ❑ Straining at Stool
❑ Coughing ❑ Sitting ❑ Turning Head ❑ Lifting ❑ Sneezing ❑ Walking ❑ Lying Down ❑ Standing

Please check the following activities that relieve your condition: ❑ Bending ❑ Sitting ❑ Lifting ❑ Standing
❑ Lying Down ❑ Turning Head ❑ Reaching ❑ Walking ❑ Ice ❑ Heat ❑ OTC Meds ❑ Prescription Meds ❑ Rest

Please check any additional symptoms you may be experiencing:

❑ Cold Sweats	❑ Headache	❑ Blurred Vision	❑ Cold Hands
❑ Face Flushed	❑ Sleep Loss	❑ Ringing in Ears	❑ Cold Feet
❑ Loss of Balance	❑ Fatigue	❑ Constipation	❑ Loss of Smell
❑ Dizziness	❑ Depression	❑ Diarrhea	❑ Loss of Taste
❑ Muscle Cramps	❑ Confusion	❑ Stomach Upset	❑ Frequent Colds

MEDICAL/FAMILY HISTORY S = Self M=Mother F=Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	Dislocated Joints	❑	❑	❑	Neck Pain
❑	❑	❑	Anemia	❑	❑	❑	Epilepsy	❑	❑	❑	Nervousness
❑	❑	❑	Arthritis	❑	❑	❑	German Measles	❑	❑	❑	Numbness
❑	❑	❑	Asthma	❑	❑	❑	Headaches	❑	❑	❑	Polio
❑	❑	❑	Back Pain	❑	❑	❑	Heart Trouble/Disease	❑	❑	❑	Poor Circulation
❑	❑	❑	Bladder Trouble/Infection	❑	❑	❑	Reproductive Disorders	❑	❑	❑	Hepatitis
❑	❑	❑	Bone Fracture	❑	❑	❑	High Blood Pressure	❑	❑	❑	Rheumatic Fever
❑	❑	❑	Cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	Rheumatism
❑	❑	❑	Chest Pain	❑	❑	❑	Kidney Disorder	❑	❑	❑	Scarlet Fever
❑	❑	❑	Concussion	❑	❑	❑	Bowel Control Loss	❑	❑	❑	Serious Injury
❑	❑	❑	Convulsions	❑	❑	❑	Menstrual Cramps	❑	❑	❑	Sinus Trouble
❑	❑	❑	Diabetes	❑	❑	❑	Multiple Sclerosis	❑	❑	❑	Tuberculosis
❑	❑	❑	Indigestion	❑	❑	❑	Muscular Dystrophy	❑	❑	❑	Venereal Disease

Have you been treated by a physician for any health condition in the last year? ❑ Yes ❑ No
Describe Condition:_____ Date of Last Physical Exam:_____

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Have you ever had a metal implant? ❑ Yes ❑ No Ever been Gunshot? ❑ Yes ❑ No

PREVIOUS ACCIDENT HISTORY:

❑ Job ❑ Auto ❑ Other 1._____ Date:_____
❑ Job ❑ Auto ❑ Other 2._____ Date:_____
❑ Job ❑ Auto ❑ Other 3._____ Date:_____

EMPLOYMENT:

Occupation/Job Title:_____ Work: ___hrs / day or week
Description of Work:_____
Job Classification: ❑ Sedentary (<5 lbs) ❑ Light (5-20 lbs) ❑ Moderate (20-50 lbs) ❑ Heavy (>50 lbs)
Lifting Frequency: ❑ Constant (67-100%/day) ❑ Frequent (33-66%) ❑ Occasional (0-32%/day)
Lifting Postures: ❑ With Arms ❑ High Near ❑ From Knee ❑ Off Posture ❑ From Torso

CONDITION'S EFFECT ON JOB PERFORMANCE:

❑ **Mild** - Painful (Can Do) ❑ **Mod** - Painful (Limited Ability) ❑ **Mod/Sev** (Limited Duty) ❑ **Sev** (No Limited Duty) ❑ **Sev** (Can't Do Limited Duty)

RECREATIONAL ACTIVITY: Effects of Current Condition on Performance:

_____❑ No Effect ❑ **Mild** - Painful (Can Do) ❑ **Mod** - Painful (Limited) ❑ **Sev** (Unable to Perform)
_____❑ No Effect ❑ **Mild** - Painful (Can Do) ❑ **Mod** - Painful (Limited) ❑ **Sev** (Unable to Perform)