PATIENT HISTORY

Last Name _____ First Name _____

Date of Birth_____ Social Security Number _____-_____-_____

Your Occupation _____

Have you ever been to another doctor for this problem? Y / N Who? _____

Have you been to a chiropractor in the last 3 years? Y / N

Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

PRIMARY COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate anywhere? Y / N _____ Arm _____ Leg _____ Head
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____Daily _____1-2 x Week _____1-2 x Month _____Constant _____Other

- PAIN INTENSITY: Circle the intensity of your pain, on a scale 1-10… 10 being the worst.
  _____1 2 3 4 5 6 7 8 9 10_____

OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate anywhere? Y / N _____ Arm _____ Leg _____ Head
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____Daily _____1-2 x Week _____1-2 x Month _____Constant _____ Other

- PAIN INTENSITY: Circle the intensity of your pain, on a scale 1-10… 10 being the worst.
  _____1 2 3 4 5 6 7 8 9 10_____

PATIENT SIGNATURE _____DATE _____