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)

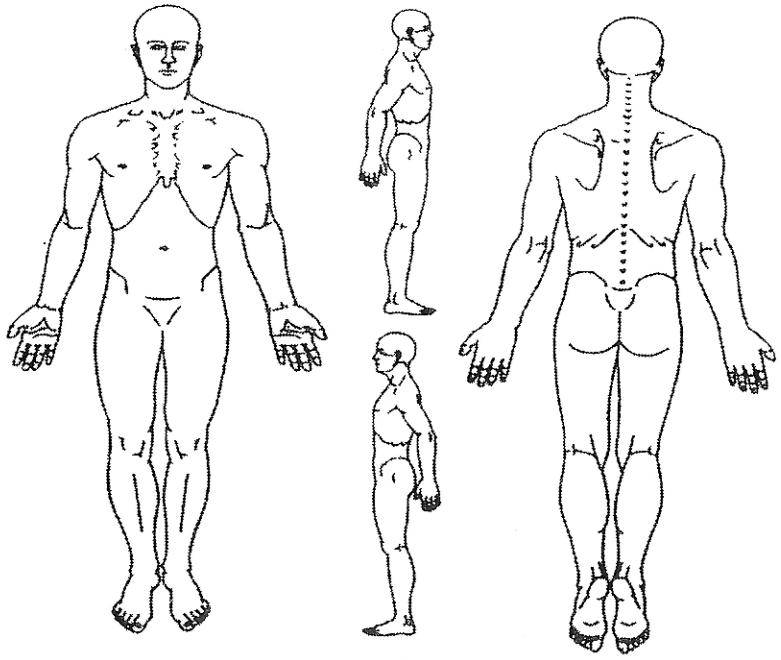
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

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



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? _____

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: ____/____/____