Date: _____

Acct: _____

Patient: _____

PATIENT HISTORY

1. What is your **main complaint?** _____

2. On the scale bellow, 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**

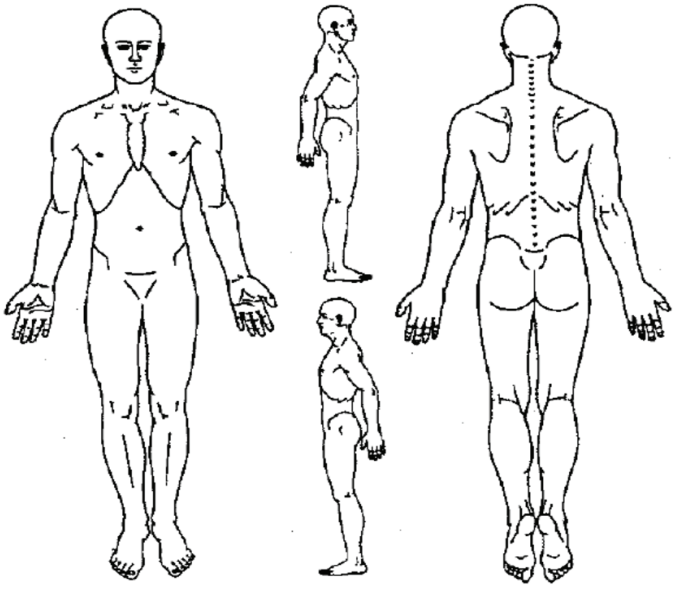
3. On the scale below, please **circle** the **percentage of time** you experience your main complaint

		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? _____ Min _____ 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 all that apply)

personal care _____
lifting _____
reading _____
concentrating _____
work _____
driving _____
sleeping _____
recreation _____
walking _____
sitting _____
standing _____
social life _____

Signature: _____

Date: _____/_____/_____