**Current Complaint:** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Level: None ~~0 1 2 3 4 5 6 7 8 9 10~~ Worst

Additional Complaints:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had similar symptoms prior? Yes  No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What this caused by? 

Slip/Fall  Car or Work Accident  Gradual Onset  Sports Injury   Other?\_\_\_\_\_\_\_\_\_\_\_

Is the pain?  Constant  Frequent, but not constant  Occasional  Activity Induced:\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel pain has changed since initial onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have you tried that has decreased the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other medical providers for these symptoms?  Yes  No

Provider name and type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any surgery/injections or previous trauma to the area? Yes No Did it help? Yes No

Have you had any of the following of the injured area? X-Ray MRI CT Bone Scan EMG Other

**Medical History**

Any other previous surgical history? Dates?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated for any other condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been involved in an auto accident, if so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had chiropractic care previously, if so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with any of the following? If so, list when and current status:

Arthritis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pacemaker/Heart Issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High/Low Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant (Y/N)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of any of the following? If so, relationship to you:

Arthritis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pacemaker/Heart Issues\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

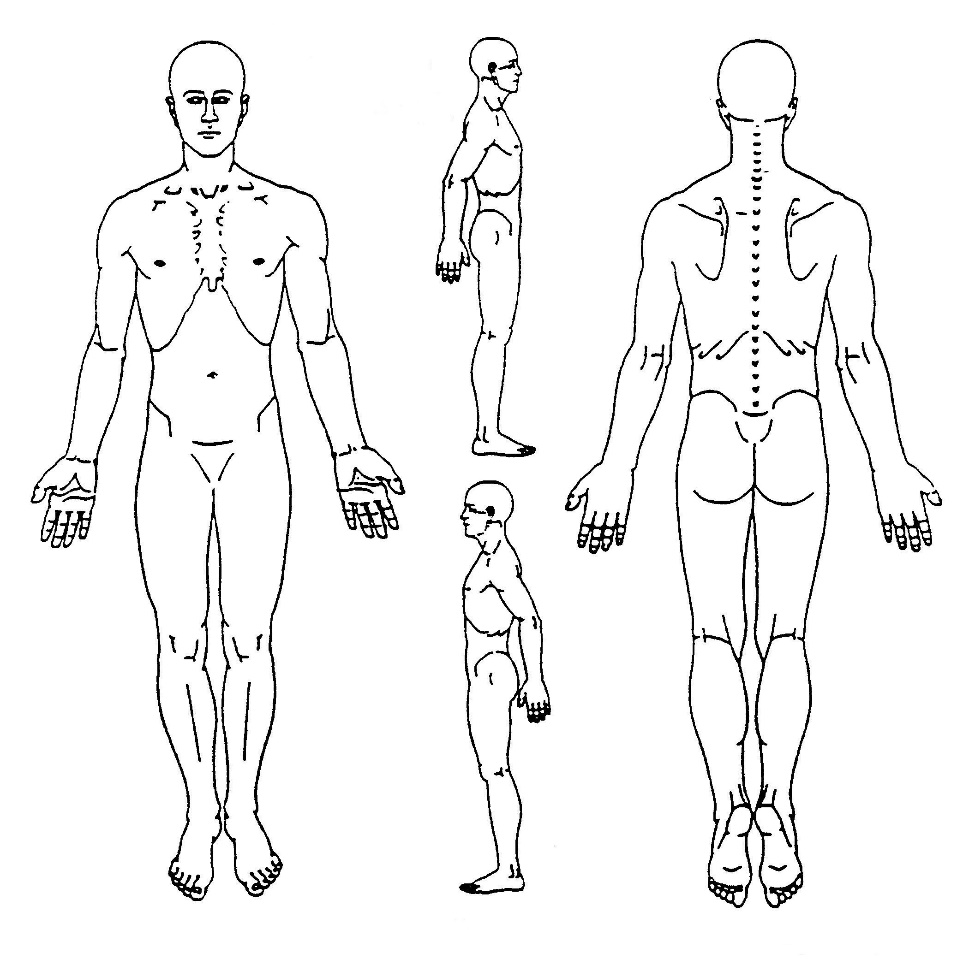
Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High/Low Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications or vitamins or supplements currently? If so, list below \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Smoke? Yes No Drink? Yes No Exercise? Yes No

Current Work Status: \_\_\_Regular Duty \_\_\_ Light Duty \_\_\_ No work Hours per week:\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark on the figures below where you are experiencing pain:**

Please describe the quality of your pain:

**\_\_\_Dull \_\_\_Achy \_\_\_Sharp \_\_\_Stabbing \_\_\_Tingling \_\_\_Numb \_\_\_Throbbing**

**Please only answer questions related to your complaint, check all that apply:**

**Neck:**

Do you have headaches? [ ] ~ Frequency: \_\_\_\_\_/month

Dizziness? [ ] ~ Frequency: \_\_\_\_\_/month Blurred Vision? [ } ~ Frequency: \_\_\_\_\_/month

Are you experiencing arm or hand pain/numbness/tingling? [ ] Is it worse recently? [ ]

Do you feel like your hands are consistently cold when they shouldn’t be?  [ ]

**Mid Back (Recent Changes Only):**

Are you experiencing pain with deep breaths? [ ] Any chest Pain? [ ]

Have you noticed heart palpitations or flutter? [ ] Have you noticed difficulty breathing? [ ]

**Lower Back Pain**:

Noticing any new leg pain/numbness/tingling? [ ] Leg weakness? [ ] Cold Feet? [ ]

Recent change in bowel/bladder habits?  [ ] Groin Numbness? [ ]

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_