



Chief Complaint: _____

Secondary Complaint: _____

Other Concerns: _____

When did your your complaint begin? _____

How did your symptoms begin? _____

Circle what makes your symptoms worse: Bending Lying Walking Standing Sitting
Movement Twisting Lifting Sleeping

What makes your symptoms better? _____

How long do the symptoms last? _____

Have the symptoms improved? Become worse? Remained the same? _____

Have you had similar symptoms before? ___ If so, when? _____

What treatment did you receive? _____

Results of previous treatment? ___Good ___Poor Comments _____

Circle what describes symptoms: dull aching sharp shooting burning throbbing deep

Do your symptoms travel or radiate to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Do the symptoms stop you from doing any of your normal activities? _____

Work Sleep Daily Routines Recreation

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible)

Have you had any conditions in the past that have left you with ongoing problems?

When do you have the symptoms? Worse in the morning? Night? No change? _____

Any other Musculoskeletal concerns? ___No ___Yes ...Neurological concerns? ___No ___Yes

List any other major injuries you have had, other than those mentioned above: _____

How did you find out about this office? _____

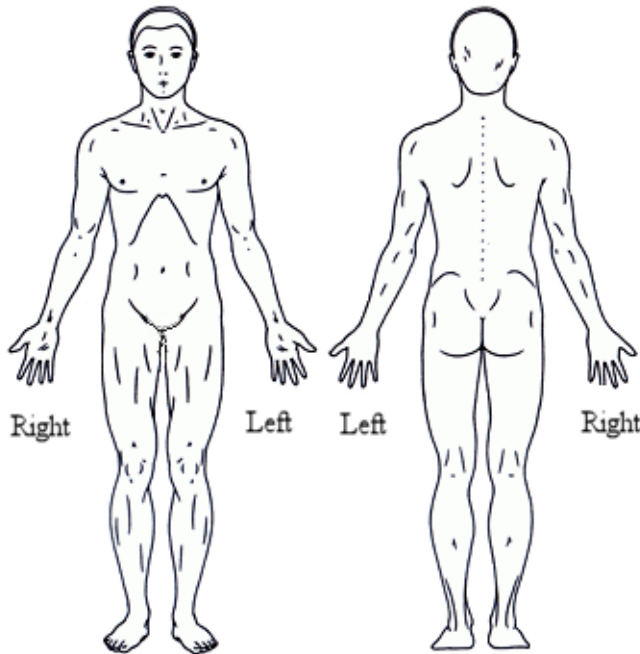
Signature

Date

Cole

Chiropractic & Wellness

Using the symbols below, mark on the pictures where you feel pain.



- Numbness = = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing / / /
- Pins, Needles + + +
- Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Menopause |



Are you under medical care for any condition? _____

What Medications are you taking? _____

How long? _____ Have you had surgery? _____ What? _____

_____ When? _____

What side effects have you experienced from the drugs and surgery?

Females Only – Date last Menstrual Period began on _____ Are you possibly Pregnant? _____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother's side	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Signature

Date