



**3. How often do you experience your symptoms?**

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

**4. How would you describe the type of pain?**

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Electric like with motion
- Other: \_\_\_\_\_

**5. How are your symptoms changing with time?**

- Getting Worse
- Not Changing
- Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0      1      2      3      4      5      6      7      8      9      10 (Please circle)

**7. How much has the problem interfered with your work?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**8. How much has the problem interfered with your social activities?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

**9. Who else have you seen for your problem?**

- Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other: \_\_\_\_\_
- No one

**10. How long have you had this problem?** \_\_\_\_\_

**11. How do you think your problem began?** \_\_\_\_\_

**12. Do you consider this problem to be severe?**

- Yes
- Yes, at times
- No

**13. What aggravates your problem?** \_\_\_\_\_

**14. What makes your problem feel better?** \_\_\_\_\_

**15. What concerns you the most about your problem (Please Pick Only One)?**

- Could be Serious
- Affecting Mental Outlook
- Not Going Away
- Affecting Relationships
- Getting Worse
- Affecting Leisure
- Affecting Work
- Other: \_\_\_\_\_
- Affecting Sleep

**16. What is your: Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**17. How would you rate your overall Health?**

- Excellent
- Very Good
- Good
- Fair
- Poor

**18. What type of exercise do you do?**

- Strenuous
- Moderate
- Light
- None

**19. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus
- ALS

**20. What impact do you believe your family history has on your own health?**

- None       Mild       Moderate       Extreme

**21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<b>For Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**22. List any prescription medications or over-the-counter medications you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

**23. List any nutritional supplements you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

**24. List all surgical procedures you have had:**

\_\_\_\_\_

\_\_\_\_\_

**25. What activities do you do at work?**

<input type="checkbox"/> <b>Sit:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Stand:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Computer work:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>On the phone:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Drives:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Walk</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Other:</b>	<input type="checkbox"/> Manual Labor	<input type="checkbox"/> Reads a lot	<input type="checkbox"/> Travels a lot

**26. What activities do you do outside of work?** \_\_\_\_\_

**27. Have you ever been hospitalized?**  No       Yes, if yes, why \_\_\_\_\_

**28. Have you seen a chiropractor before?**  No       Yes

If yes, who: \_\_\_\_\_ how long ago: \_\_\_\_\_ results were:  Good     Mixed     Bad

**29. Have you had significant past trauma?**  No       Yes, if yes list: \_\_\_\_\_

**30. Anything else pertinent to your visit today?** \_\_\_\_\_

I authorize this office to release any information requested by my insurance company or other health care individuals to document my claim for benefits or assist in further health care purposes. The above information was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health status or financial status.

**Patient (or Guardian) Signature** \_\_\_\_\_ **Date** \_\_\_\_\_