



Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

List your Pains/Complaints from Most Severe (1) to Least Severe (4)

	1.	2.	3.	4.
Today, I have the following physical complaints:	_____	_____	_____	_____
Is this Complaint Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (explain)?	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Electric / Shooting
How often do you feel this Complaint? Constant, Daily, "Off & On" or Weekly?	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	<input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Off & On <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
How long have you had this complaint?	_____	_____	_____	_____
Is it getting better, worse, or staying the same?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What makes it better?	_____	_____	_____	_____
What makes it worse?	_____	_____	_____	_____
On a scale of 1 to 10 Rate your discomfort.	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1 10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1 10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1 10 = Excruciating 0 = No discomfort	<u>Circle one:</u> 10 9 8 7 6 5 4 3 2 1 10 = Excruciating 0 = No discomfort
How have you taken care of this in the past? How has it worked for you?	_____	_____	_____	_____
This issue is affecting my:	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine	<input type="checkbox"/> Job <input type="checkbox"/> Childcare <input type="checkbox"/> Marriage <input type="checkbox"/> Sex <input type="checkbox"/> Golf <input type="checkbox"/> Finances <input type="checkbox"/> Playing with Kids <input type="checkbox"/> Bowels <input type="checkbox"/> Urine
Helping this issue would increase my Quality of life by:	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%	<input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40% <input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80% <input type="checkbox"/> 90% <input type="checkbox"/> 100%



### Confidential Patient Health Record

Today's

Date: \_\_\_/\_\_\_/\_\_\_

How did you hear about us?  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Dr. \_\_\_\_\_  Yellow pages  Drove by  Hospital  Insurance Plan

#### Personal Information

Title:  Mr.  Ms.  Mrs.  Dr.  Rev.  Miss  Prof.  other: \_\_\_\_\_  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  MD  PhD  DO  Esq  PA  RN  BSN  other: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female Social Security #: \_\_\_-\_\_\_-\_\_\_  
Primary Language:  English  French  German  Spanish  other: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_  
Blood Type:  A positive  A negative  B positive  B negative  AB positive  AB negative  O positive  O negative  
Race:  African American  Asian  Caucasian  Hispanic  Multiracial  Native American  Other: \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

#### Emergency Contact

Title:  Miss  Mrs.  Ms.  Master  Mr.  Dr.  Prof.  Rev.  other: \_\_\_\_\_  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  MD  PhD  DO  Esq  PA  RN  BSN  other: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_-\_\_\_-\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Medical Doctor's Name \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAD**

- Chills Daytime Drowsiness Fatigue Fever Night Sweats Weight Gain/Loss Dizziness
- Eyes/Vision**  
 Blindness Blurred Vision Cataracts Double Vision Eye Pain Glaucoma Wear glasses
- Ears, Nose, Throat**  
 Bleeding Dentures Difficulty Swallowing Discharge Ear Pain Fainting Hearing loss  
 Hoarseness Nasal Congestion Runny Nose Sinus Infections Snoring Sore Throat  
 Ringing in Ears TMJ Headaches
- Respiration**  
 Asthma Cough Sputum production Blood in sputum Wheezing Allergies
- Cardiovascular**  
 Angina (chest pain) leg pain Heart Murmur High Blood Pressure Low Blood Pressure Ulcers  
 Varicose Veins Swelling of legs Shortness of Breath Palpitations Difficulty breathing
- Female**  
 Birth Control Breast Lumps Cramps Burning Urination Urine Retention Frequent Urination  
 Hormone Therapy Irregular Menstruation Pregnancy Vaginal Bleeding/Discharge
- Male**  
 Burning Urination Urine Retention/Dripping Frequent Urination Erectile Dysfunction Prostate Issues
- Endocrine**  
 Heat/Cold Intolerance Diabetes Goiter Hair Loss Voice Changes Unusual Hair Growth  
 Abnormal Frequency in Urination Excessive Thirst/ Hunger/ Appetite
- Skin**  
 Nail Texture Changes Skin Color Changes Hair Growth/ Loss Hives History of Skin Disorder Rash  
 Itching Skin Lesions/ Ulcers Varicosities
- Nervous System**  
 Dizziness Facial Weakness Headache Limb Weakness Loss of Consciousness Seizures  
 Numbness Sleep Disturbances Stress Stokes Tremor Loss of Balance Loss of Memory  
 Slurred Speech
- Psychologic**  
 Behavioral Change Convulsions Memory Loss Anxiety Loss or Change in Appetite  
 Bi-Polar Disorder Confusion Depression Insomnia Mood Change Anorexia Bulimia
- Allergy**  
 Anaphalaxis Itching Food Intolerance Rash Sneezing Acute/Chronic Nasal Congestion
- Hematologic**  
 Anemia Bleeding Blood Clotting Blood transfusion Bruising Easily Fatigue  
 Lymph Node Swelling
- Allergic to any food/medication etc**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

DOCTOR: \_\_\_\_\_

**Do you have any of the following**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD             | <input type="checkbox"/> cystic kidney disease  | <input type="checkbox"/> hypertension                 | <input type="checkbox"/> psychiatric problems             |
| <input type="checkbox"/> alzheimers      | <input type="checkbox"/> depression             | <input type="checkbox"/> influenzal pneumonia         | <input type="checkbox"/> scoliosis                        |
| <input type="checkbox"/> anemia          | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease                | <input type="checkbox"/> seizures                         |
| <input type="checkbox"/> arthritis       | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease                 | <input type="checkbox"/> shingles                         |
| <input type="checkbox"/> asthma          | <input type="checkbox"/> eczema                 | <input type="checkbox"/> lupus erythema (discoïd)     | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer          | <input type="checkbox"/> emphysema              | <input type="checkbox"/> lupus erythema (systemic)    | <input type="checkbox"/> STD's (unspecified)              |
| <input type="checkbox"/> cerebral palsy  | <input type="checkbox"/> eye problems           | <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> suicide attempt(s)               |
| <input type="checkbox"/> chicken pox     | <input type="checkbox"/> fibromyalgia           | <input type="checkbox"/> parkinson's disease          | <input type="checkbox"/> thyroid problems                 |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease          | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo                          |
| <input type="checkbox"/> CRPS (RSD)      | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> pneumonia                    | <input type="checkbox"/> Bedwetting                       |
| <input type="checkbox"/> CVA (stroke)    | <input type="checkbox"/> HIV                    | <input type="checkbox"/> psoriasis                    | <input type="checkbox"/> Joint Replacment                 |
| <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> Spina Bifida           | <input type="checkbox"/> sickle cell anemia           | <input type="checkbox"/> headaches                        |
| <input type="checkbox"/> Broken Bones    | <input type="checkbox"/> D & C                  | <input type="checkbox"/> Angioplasty                  | <input type="checkbox"/> Caesarian section                |
| <input type="checkbox"/> Appendectomy    | <input type="checkbox"/> Carpal Tunnel Repair   | <input type="checkbox"/> Heart Bypass                 | <input type="checkbox"/> Gall bladder removed             |
| <input type="checkbox"/> Hernia Repair   | <input type="checkbox"/> Hysterectomy           | <input type="checkbox"/> Hemorrhoidectomy             | <input type="checkbox"/> Knee / Shoulder Repair           |
| <input type="checkbox"/> Laminectomy     | <input type="checkbox"/> Mastectomy             | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Other                            |

Name: \_\_\_\_\_

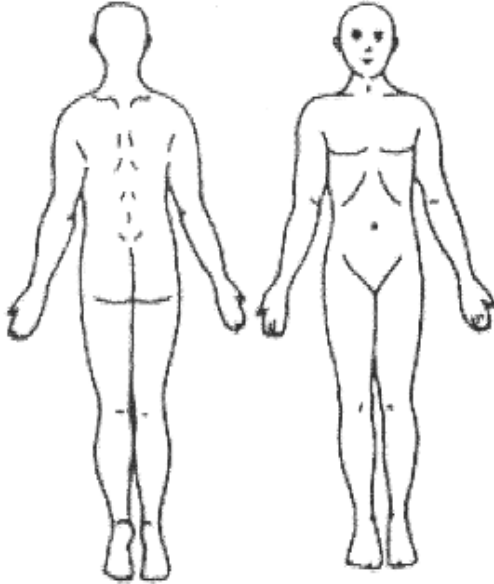
Date: \_\_\_\_\_

Doctor: \_\_\_\_\_

**Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.**

Key: A=Ache B=Burning N = Numbness  
 P=Pins & Needles S=Stabbing

Have you been treated for this before? \_\_\_\_\_  
 Where & When \_\_\_\_\_  
 Outcome? \_\_\_\_\_  
 Treatment \_\_\_\_\_



**Previous Chiropractic Care:** Doctor: \_\_\_\_\_  
 When: \_\_\_\_\_ Where: \_\_\_\_\_  
 Satisfied with Care? \_\_\_\_\_ Last chiropractic visit \_\_\_\_\_

**Current Medications:** \_\_\_\_\_  
 \_\_\_\_\_

**Current Supplements:** \_\_\_\_\_  
 \_\_\_\_\_

**Social History:** How much? How many times a week / years? What Kind?  
 Alcohol: \_\_\_\_\_ Smoking: \_\_\_\_\_

Illegal Drugs: \_\_\_\_\_  
**Family History:** Diseases, Causes of Death, (ex: Diabetes, Osteoporosis, Cancer)  
 Mother's Side:  
 Father's Side:  
 Siblings:

**VAS Scale:** 1 is no effect, 10 is worst possible  
 Level of Impairment: Resting: 1 2 3 4 5 6 7 8 9 10  
 Level of Impairment: Activity: 1 2 3 4 5 6 7 8 9 10

**Job Performance / ADL's / Recreation /**

**Condition's Effect On Job Performance:** **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited ability)  
**Mod/Sev** Limited Duty **Sev** No Limited Duty  **Sev** (can't do limited duty) **Resolved**

**Daily Activities: Effects of Current Condition on Performance**

- Bending:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Care -Infirm Family:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Carrying Groceries:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Change Posn-Sit-Stand:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Climb Stairs:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Driving:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Extended Computer Use:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Feeding:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Household Chores:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Kneeling:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Lift Children:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Lifting:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Pet Care:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Reading (Concentration):  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care-Bathing:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care-Dressing:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care-Shaving:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Sexual Activities:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Sleep:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Static Sitting:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Static Standing:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Walking:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Yard Work:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform

**Recreational Activity:**

- \_\_\_\_\_ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform **Resolved**
- \_\_\_\_\_ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform **Resolved**
- \_\_\_\_\_ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform **Resolved**