



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: _____

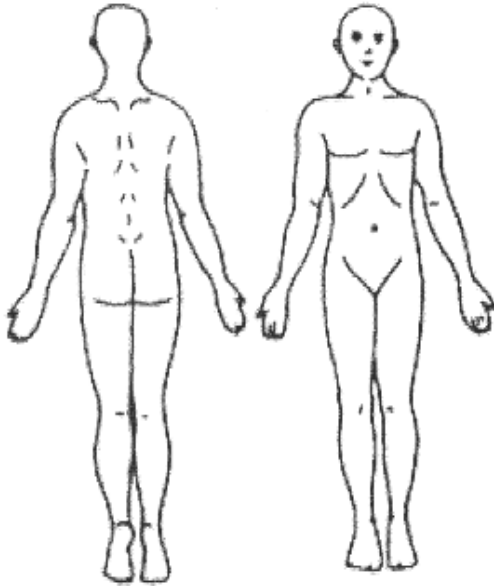
Date: _____

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**