



**HISTORY OF PRESENTING ILLNESS/INJURY**

What are your symptoms? \_\_\_\_\_

Date symptoms began? \_\_\_\_\_ How did it occur? \_\_\_\_\_

\_\_\_ Work Related \_\_\_ Auto Accident Related Missed work or school? \_\_\_ No \_\_\_ Yes, how many days? \_\_\_\_\_

Have you tried any self-remedies, ice, heat, massage, etc. \_\_\_\_\_

Have you seen any other providers for the condition you are seeing us today? \_\_\_\_\_

Have you received any prior treatment for this condition? \_\_\_\_\_

Have you ever seen a chiropractor before, if so, whom? \_\_\_\_\_

How many times have you had this condition previously? Never 1-3 times 4+ times

Have you had recent x-rays or other imaging of the area, if so, where were they taken? \_\_\_\_\_

Do you have any other health conditions? Please circle all that apply.

Diabetes High Blood Pressure High Cholesterol Asthma IBS/Cholitis Cancer

Arthritis Infertility Issues Other \_\_\_\_\_

**Females:** Are You Pregnant? \_\_\_ No \_\_\_ Yes, Estimated Due Date? \_\_\_\_\_

**Describe any major illnesses, accidents, injuries, hospitalizations, or surgeries**

Date	Doctor/Hospital	Condition(s)	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SOCIAL HISTORY**

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_

Recreational Activities/Hobbies \_\_\_\_\_

Do You Exercise \_\_\_No \_\_\_Yes How Often? \_\_\_\_\_ In What Way? \_\_\_\_\_

Do You Consume Caffeine? \_\_\_No \_\_\_Yes How Much? \_\_\_\_\_ How Often? \_\_\_\_\_

Do You Consume Alcohol? \_\_\_No \_\_\_Yes How Much? \_\_\_\_\_ How Often? \_\_\_\_\_

**FAMILY HISTORY List any current or past health conditions of your family members. ( if deceased, list age and cause of death)**

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_ How Many? \_\_\_\_\_

Sisters \_\_\_\_\_ How Many? \_\_\_\_\_

Children \_\_\_\_\_ How Many? \_\_\_\_\_

**SYSTEM REVIEW QUESTIONS** Have you had any problems with the following areas, now or in the past? **Circle specific issues.**

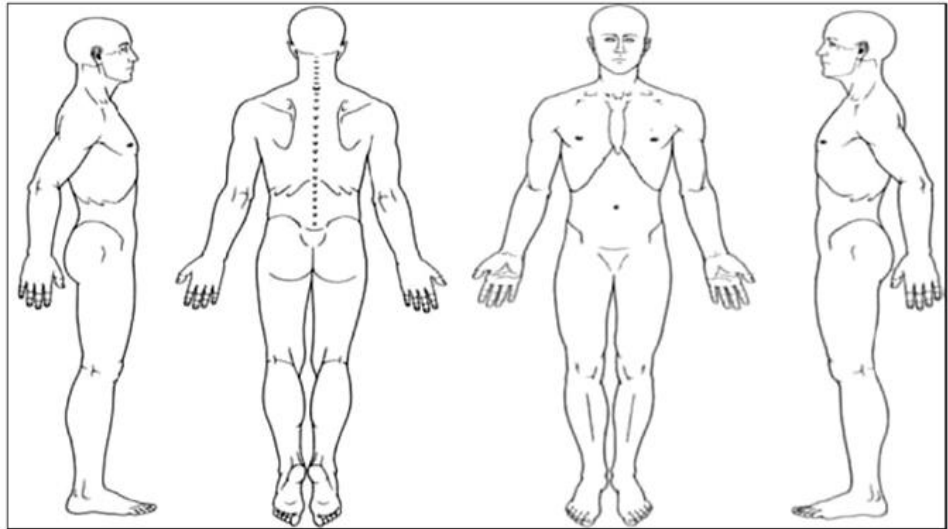
- \_\_\_ EYES (GLASSES, CONTACTS, CATARACTS, GLAUCOMA, ETC.)
- \_\_\_ GASTRO-INTESTINAL (ACID REFLUX, ULCERS, GALL BLADDER, IBS, ETC.)
- \_\_\_ EARS, MOUTH, NOSE, THROAT (HEARING LOSS, SINUS, ETC.)
- \_\_\_ GENITO-URINARY (MALE/FEMALE REPRODUCTION, KIDNEYS, BLADDER, ETC.)
- \_\_\_ CARDIOVASCULAR (HEART, HIGH B.P., HIGH CHOLESTEROL, STROKE)
- \_\_\_ MUSCULOSKELETAL (BREAKS, ARTHRITIS, OSTEOPOROSIS, DISCS, ETC.)
- \_\_\_ RESPIRATORY (LUNGS, BREATHING, ASTHMA, C.O.P.D., ETC.)
- \_\_\_ SKIN (RASHES, SKIN CANCER, DRYNESS, PSORIASIS, ECZEMA, HAIR, ETC.)
- \_\_\_ NEUROLOGICAL (NERVE ISSUES, M.S., WEAKNESS, NUMBNESS, ETC.)
- \_\_\_ PSYCHIATRIC (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC.)
- \_\_\_ ENDOCRINE (THYROID, HORMONAL IMBALANCES, LIVER, ETC.)
- \_\_\_ CONSTITUTIONAL (FEVER, CHILLS, NAUSEA, DIZZINESS, ETC.)
- \_\_\_ INTERNAL ORGANS (DIABETES, APPENDIX, SPLEEN, LIVER, ETC.)
- \_\_\_ HEMATOLOGICAL (ANEMIA, THIN BLOOD, SICKLE CELL, ETC.)

OTHERS: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S)**

Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 100 (0 = no pain; 100 = intolerable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

- X X X** Burning Pain
- \_ ( ( (** Aching Pain
- 0 0 0** Pins & Needles
- - - -** Numbness
- \_ : : :** Sharp Pain
  
- Constant
- Comes/Goes
- Fluctuates
  
- Getting Better
- Getting Worse
- Staying Same
  
- Better: Worse:**
- AM
- MID-DAY
- PM



**NO PAIN PAIN SCALE: INTOLERABLE**

0 \_ 5 \_ 10 \_ 15 \_ 20 \_ 25 \_ 30 \_ 35 \_ 40 \_ 45 \_ 50 \_ 55 \_ 60 \_ 65 \_ 70 \_ 75 \_ 80 \_ 85 \_ 90 \_ 95 \_ 100

**What Makes Condition BETTER?**

- Head / Neck:  Heat  Cold  Meds  Chiropractic Other: \_\_\_\_\_
- Mid Back:  Heat  Cold  Meds  Chiropractic Other: \_\_\_\_\_
- Low Back:  Heat  Cold  Meds  Chiropractic Other: \_\_\_\_\_
- Shoulder, Arm, Wrist, Hand:  Heat  Cold  Meds  Chiropractic Other: \_\_\_\_\_
- Hip, Leg, Ankle, Foot:  Heat  Cold  Meds  Chiropractic Other: \_\_\_\_\_
- Other: \_\_\_\_\_ Heat  Cold  Meds  Chiropractic Other: \_\_\_\_\_

**What Makes Condition WORSE?**

- Head / Neck: \_\_\_\_\_
- Mid Back: \_\_\_\_\_
- Low Back: \_\_\_\_\_
- Shoulder, Arm, Wrist, Hand: \_\_\_\_\_
- Hip, Leg, Ankle, Foot: \_\_\_\_\_
- Other: \_\_\_\_\_

**Indicate your Ability to Perform the Following Activities of Daily Living. Please use the following codes:**

**U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven’t Tried**

- Lying on Back  Dressing Self  Lifting  Kneeling  Twist/Turn – LEFT / RIGHT
- Lying on Sides  Stooping  Gripping  Bending Forward  Sitting/Driving/Riding
- Lying on Stomach  Pushing/Pulling  Standing  Get In/Out of Car  Using Computer
- Turning Over in Bed  Reaching  Walking  Sexual Activity  Using Stairs
- Cough/Sneeze/Grunt – (if painful, where \_\_\_\_\_)
- Sleeping - (# times wake up \_\_\_\_\_ ; # pillows \_\_\_\_\_ ; position sleep in: \_\_\_\_\_)

**Notes**

## Please answer all questions for the affected areas:

The following scales have been designed to find out about your back/neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your pain?

	No pain					Worst pain possible					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

	No interference					Unable to carry out activity					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social and family activities?

	No interference					Unable to carry out activity					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

4. Over the past week, how anxious (tense, uptight, irritable, difficult in concentrating/relaxing) have you been feeling?

	Not anxious					Extremely anxious					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

5. Over the past week, how depressed (down in the dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

	Not depressed					Extremely depressed					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected your pain?

	No worse					Much worse					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

	Completely control it					No control whatsoever					
BACK	0	1	2	3	4	5	6	7	8	9	10
NECK	0	1	2	3	4	5	6	7	8	9	10

**Quad Visual Analog Scale:** Please rate your symptoms on a scale of **0** (No pain) to **10** (Worst Imaginable).

Area	Best	Worst	Now	Usual
Neck				
Mid Back				
Low Back				

**Patient Specific Function:** Please rate each activity on a 0-10 scale.

Walking \_\_\_\_\_

Standing \_\_\_\_\_

Laying \_\_\_\_\_

Bending \_\_\_\_\_

Score \_\_\_\_\_ Percent Score \_\_\_\_\_

**CLINIC USE ONLY : (Vitals age 2 yrs+)**

Height \_\_\_\_\_ inches; Weight \_\_\_\_\_ lbs; Pulse \_\_\_\_\_; Respir; \_\_\_\_\_; Temp; \_\_\_\_\_;

Blood Pressure (Left Arm/Right Arm) \_\_\_\_\_/\_\_\_\_\_ ( Sitting / Standing / Supine ) Staff Initials \_\_\_\_\_