

Information about your current condition/complaints

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What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: Constant Intermittent

Is your condition getting worse? _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List all Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____

2. _____

3. _____

Have you had: Xray MRI or CAT Scan EMG Bone Scan Blood Work

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

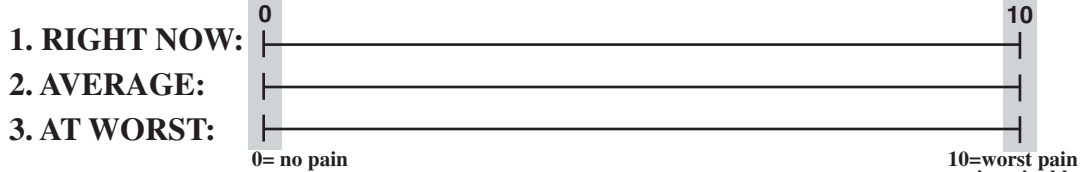
Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work _____ sleep _____ normal daily routine _____

Have you had symptoms like this before? no yes (describe) _____

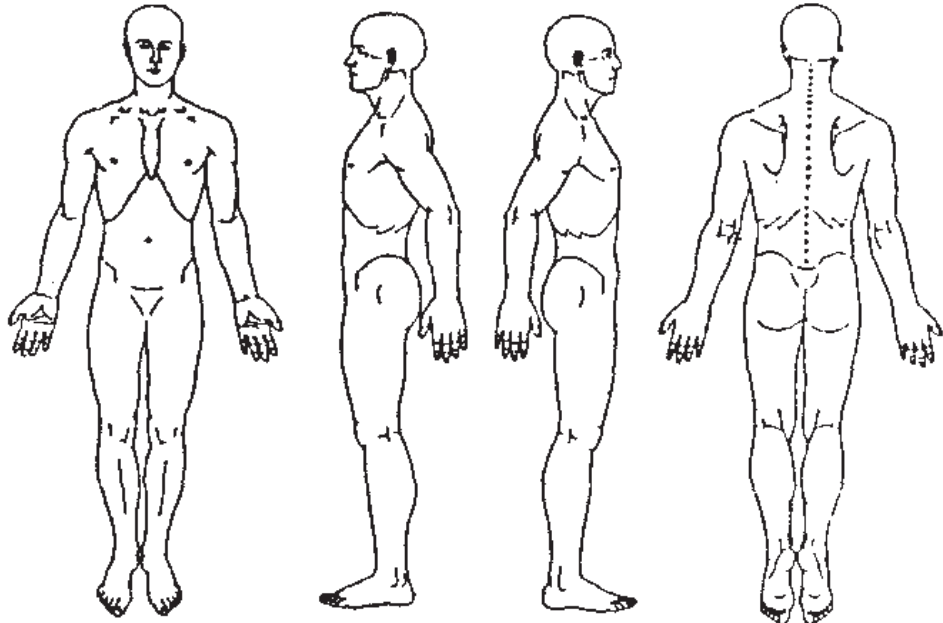
Regarding your main complaint:

How bad is your pain?
(make a slash on all 3 scales)



Draw the area
of your symptoms
using these symbols:
(mark on the figures)

- XXX = ache
- * = sharp/stab
- ooo = numb/tingle
- = shooting
- //// = stiff/tight



Pt. History 3.1
#1.04 SCS1©

NOTICE TO NEW PATIENTS: Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

Patient Signature: _____ Date _____