

Initial Symptom History

Please state your primary complaint of why you are here today: _____

How long have you had this? _____

What activities does your condition prevent you from doing: _____

Please put a check that applies to your present condition:

Frequency: ___rare ___occasional ___frequent ___constant

Symptoms: ___pain ___stiffness ___spasms

Intensity: 0 (none)- 10 (severe) = ___neck ___mid ___low back ___extremity

Quality: ___sharp ___dull ___stabbing

Assoc. Symptoms: ___weakness ___limited ranges of motion

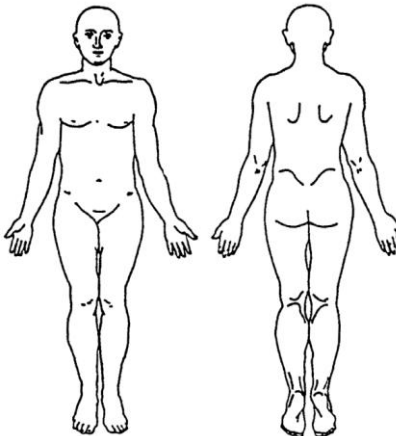
___radiating pain into _____

___numb/tingling of _____

Aggravated by prolonged: ___sitting ___standing ___walking ___lying down ___driving

Relieved by: ___rest ___movement ___stretching ___Rx ___ice ___heat

Please mark the areas where your current complaints are located:



Signature _____ Date _____

INITIAL HEALTH HISTORY

Allergies: _____

Medications/Supplements _____

Cholesterol Lowering Drugs: _____

Surgeries/Hospitalizations: _____

Pace Maker/Metal /Breast Implants _____

Cancer: _____

Diabetes: _____

Heart Disease: _____

Stomach/Colon: _____

Etc. _____

Spinal Injuries/Accidents: _____

Previous Chiropractic Care: _____

Last Menstrual Period: _____ PREGNANT? () YES () NO

Previous MRI, CT Scans; X-Rays: _____

Sports Activities: _____ times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ()very high ()high ()medium ()minimal

Patient Signature _____ **Date** _____

Comments: