PATIENT HEALTH HISTORY

Name: _____ Today's Date _____

INSTRUCTIONS Please FILL-IN or CIRCLE all responses. If you have questions, please ask a staff member for assistance.

1. Chief Complaint (What problem(s) or condition(s) would you like us to examine?) _____

_____

2. Please explain how the injury started. Unknown No Injury Old Injury Slip or Fall Overexertion Repetitive Use Slept Wrong
   Other (Explain) _____

3. When did your symptoms start? _____ What were you doing? _____

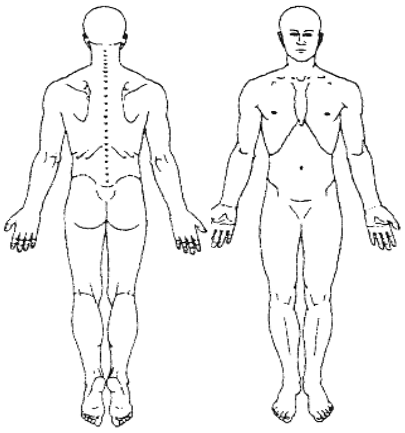
4. Have the symptoms ever occurred before? Yes No If Yes, when and how often? _____

5. How would you describe your current symptoms? Sharp/Shooting Pain Radiating Pain Localized Pain Diffuse Pain Dull Ache
   Numbness/Tingling Stiffness Weakness Burning Throbbing
   Other (Explain) _____

6. Rate your level of PAIN. (0=No Pain, 10=Severe Pain) 0---1---2---3---4---5---6---7---8---9---10

7. Rate how you pain interferes with Activity. (0=No Pain, 10=Severe Pain) 0---1---2---3---4---5---6---7---8---9---10

8. Please mark the area of your symptoms on the diagram to the right.



9. Is your condition? Worsening Improving Unchanging Constant Comes and Goes

10. When is your condition worse? Morning Afternoon Night With Activity

11. Do your symptoms seem to be better with? Nothing Stretching Cold Heat
    Rx Medications Massage Movement Walking Standing Sitting Rest
    OTC Medications Exercise Chiropractic Bending Activity
    .

12. Circle any of the following signs or symptoms that are associated with your current condition.

Joint Stiffness	Restricted Motion	Muscle Spasm	Redness	Deformity
Headaches	Loss of Coordination	Weakness	Cold Limb	Heat
Radiating Pain	Abnormal Sensation	Swelling	Nausea	Fatigue
Body Ache	Numbness /Tingling	Dizziness	Vomiting	

PAST HEALTH HISTORY

13. Please list any other doctors or providers that you have seen for your condition(s) and the treatment provided. _____

_____

14. Adult and Childhood Illnesses. (Please list any significant or current illnesses.) _____

_____

15. Surgeries. (Please list all surgical procedures that have had in the past and approximate date.) _____

_____

16. Injuries. (Please list any significant injuries, falls, trauma, accidents that you have had in the past.) _____

_____

Reviewed by: _____ D.C.