Patient History

Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when/who? _____

1. *What Would You Like Help With? _____
(Describe primary complaint/problem) _____
_____

*Grade **Intensity/Severity** of problem/complaint *-please (X) 1 box for each complaint*

-please specify location:	(No complaint/pain) 0	1	2	3	4	5	6	7	8	9	10 (Worst possible pain/complaint imaginable)
***1** _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2 _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3 _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

*How **Frequent** is complaint present, how long does it last**?** *-please (X) 1 box for each complaint*

-please specify location:	Periodic *0 - 25% of day*	Occasional *25-50% of day*	Frequent *50-75% of day*	Constant *75-100% of day*
***1** _____	☐	☐	☐	☐
2 _____	☐	☐	☐	☐
3 _____	☐	☐	☐	☐

*Please *(X)* the **Quality** of the complaint/pain: *-please (X) as many that apply*
☐ dull ☐ aching ☐ sharp ☐ shooting ☐ burning ☐ throbbing
☐ deep ☐ nagging ☐ other _____

*Does this complaint/pain ***travel (shoot) or radiate*** to any areas of your body? ☐ Yes ☐ No
If yes, Where? _____

*Do you have any ***numbness or tingling*** in your body? ☐ Yes ☐ No
If yes, Where? _____

***When and How did it begin?**
*It started: _____ ☐ Day(s) ☐ Week(s) ☐ Month(s) ☐ Year(s)
If persistent, was it aggravated recently? _____ ☐ Day(s) ☐ Week(s) ☐ Month(s)

*Problem/complaint came on: ☐ Gradually ☐ Suddenly

***How did it occur?**
☐ Unknown ☐ While Lifting ☐ a Fall ☐ Trauma ☐ Degenerative Process
☐ Overuse ☐ Car Accident ☐ Sleeping ☐ Recreation/Sport: _____
☐ Other: _____
_____

*Anything make the complaint ***worse***? *-please (X) as many that apply*
☐ Sitting ☐ Standing ☐ Seated to Standing ☐ Walking Up/Down Stairs ☐ Lying Down
☐ Looking Up ☐ Overhead Reach ☐ Overhead Reach In Front ☐ Reach Behind Back ☐ Reach Across Body
☐ Repetitive Activity ☐ Household Activities ☐ Sports/Recreation ☐ Squatting ☐ Sustained Bending
☐ Cough ☐ Deep Breathing ☐ Sleeping ☐ Stress ☐ Talking
☐ Chewing ☐ Swallowing ☐ Yawning
☐ Other: _____

*Anything make the complaint ***better***? *-please (X) as many that apply*
☐ Nothing ☐ Medication ☐ Sitting ☐ Standing ☐ Walking
☐ Rest ☐ Cold ☐ Heat ☐ Wearing a splint/orthotics
☐ Lying Down ☐ Stretching ☐ Exercise ☐ Massage
☐ Other: _____

*Have you seen anyone else for **today's** problem/complaint? ☐ Yes ☐ No
If yes, when/who? (*Previous interventions, treatments, medications, surgery, or care you've sought for **this** complaint/problem)*
_____
_____
_____

Functional Rating Index

*(For **Neck** and/or **Back** problems/complaints Only)*

-Please (X) all that apply

1. Pain Intensity

0	1	2	3	4
No Pain	*Mild Pain*	*Moderate Pain*	*Severe Pain*	*Worst Possible Pain*

2. Sleeping

0	1	2	3	4
Perfect Sleep	*Mild disturbed sleep*	*Moderate disturbed sleep*	*Greatly disturbed sleep*	*Totally disturbed sleep*

3. Personal Care *(Washing, Dressing, Cooking, etc.)*

0	1	2	3	4
No-pain No restrictions	*Mild-pain No restrictions*	*Moderate pain; need to go slow*	*Moderate pain; need some assistance*	*Severe pain; need 100% assistance*

4. Travel *(Driving, etc.)*

0	1	2	3	4
No pain on long trips	*Mild pain on long trips*	*Moderate pain on long trips*	*Severe pain on short trips*	*Worst pain on short trips*

5. Work

0	1	2	3	4
Can Do usual work plus unlimited extra work	*Can Do usual work; no extra*	*Can Do 50% of usual work*	*Can Do 25% of usual work*	*Cannot Work*

6. Recreation

0	1	2	3	4
Can Do all activities	*Can Do most activities*	*Can Do some activities*	*Can Do a few activities*	*Cannot do any activities*

7. Frequency of Pain

0	1	2	3	4
No pain	*Occasional pain; 25% of the day*	*Intermittent pain; 50% of the day*	*Frequent pain; 75% of the day*	*Constant pain; 100% of the day*

8. Lifting

0	1	2	3	4
No pain with Heavy weight	*Increased pain with Heavy weight*	*Increased pain with Moderate weight*	*Increases pain with Light weight*	*Increased pain with Any weight*

9. Walking

0	1	2	3	4
No pain, any distance	*Increased pain, after 1 mile*	*Increased pain, after 1/2 mile*	*Increases pain, after 1/4 mile*	*Increased pain, with All walking*

10. Standing

0	1	2	3	4
No pain after several hours	*Increased pain after several hours*	*Increased pain after 1 hour*	*Increases pain after 1/2 hour*	*Increased pain with any standing*

Any Other Complaints/Problems?

_____

_____

Within the past year, have you had any of the following symptoms? *-Please (X) all that apply*

- ☐ Unable to control bowel/bladder
- ☐ Fever/Chills
- ☐ Unexplained Fatigue
- ☐ Numbness of Genitalia
- ☐ Dizziness/Fainting
- ☐ Unexplained Weakness
- ☐ Unexplained change in weight
- ☐ Night Pain/Sweats
- ☐ Malaise
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Other:_____

Past Health History: *-Please (X) all that apply*

- ☐ ADD
- ☐ AIDS/HIV
- ☐ Allergies/Hayfever
- ☐ Ankle Sprains
- ☐ Ankylosing spondylitis
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma Diabetes
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Brain Injury
- ☐ Cancer Fracture
- ☐ Carpal Tunnel
- ☐ Cystic Fibrosis
- ☐ Developmental Delay
- ☐ Epilepsy/Seizures
- ☐ Falls
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Headaches
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Hernia
- ☐ Lung Disease
- ☐ Lymphedema
- ☐ Meniere's Disease
- ☐ Muscle/Bone Problem
- ☐ Neck Injury
- ☐ Orthotics
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Peripheral Vascular
- ☐ Rheumatoid Arthritis
- ☐ Serious Illness/Injury
- ☐ Skin Sensitivities
- ☐ Stroke
- ☐ Neuropathy
- ☐ Neurological Disorder
- ☐ Urinary Problems
- ☐ Vertigo
- ☐ Other:_____

Surgery History: (please list & include dates (mo/year):

Date	*Type of Surgery*

Medications:

Medication Name	*Reason for Taking*

Allergies: _____