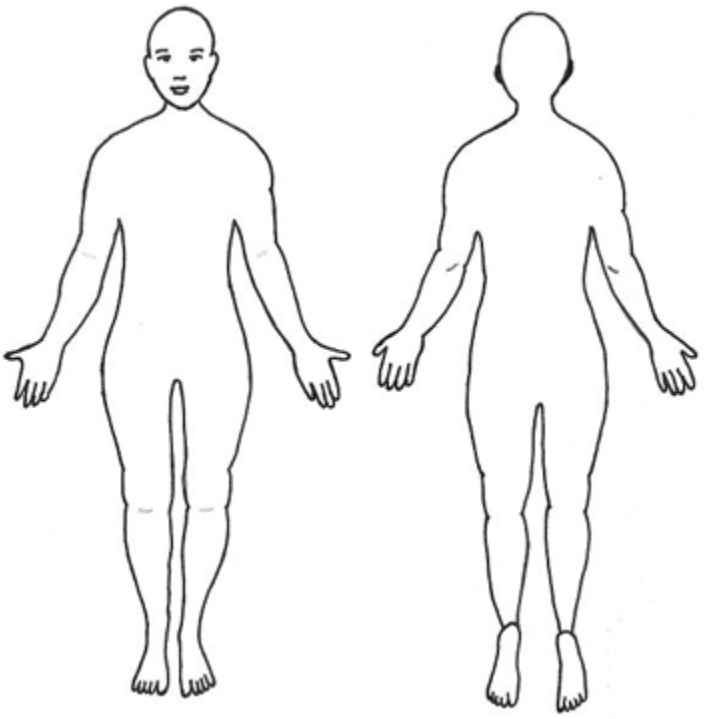
CENTRAL CHIROPRACTIC

Patient Name _____ **Date** _____

What is your reason for your appointment today (what are your symptoms)?

_____

_____



Please identify your areas of concern by marking the affected body part(s) in this illustration.

Then list the body part below and indicate the symptoms associated with your selected body part(s).

Finally, rate the severity of the symptom, with 1 being barely noticeable, and 10 being severe discomfort.

Body Part of Concern	Burning	Dull Ache	Sharp Stabling	Throbbing	Numbness	Tingling	Shooting Pain	Swelling	Stiffness	1 = Barely, 10 = Severe
Example : Low Back Pain			X		X			X		1 2 3 4 5 6 7 **8** 9 10
										1 2 3 4 5 6 7 8 9 10
										1 2 3 4 5 6 7 8 9 10
										1 2 3 4 5 6 7 8 9 10
										1 2 3 4 5 6 7 8 9 10

CENTRAL CHIROPRACTIC

Patient Name _____ **Date** _____

When did your symptoms begin to bother you?

_____

Have you ever had the symptoms before, and if so, when?

_____

What makes your symptoms better? (Please Circle) Ice Heat Medication Other (please describe)

_____

What makes your symptoms worse? (Please Circle) Coughing Sneezing Bowel Movements Urination Bending Over Twisting Body Turning Head Pushing Pulling Sitting Getting Up Standing Sleeping Lying Down Walking Running Lifting Reading Working Daily Routine Driving Other (please describe)

_____

Would you say that your symptoms are (please circle): Increasing – Decreasing – Staying the Same

What time do notice your symptoms (please circle): Morning - Afternoon - Evening - At Night While Sleeping

How often do you notice your symptoms (please circle):

Constantly (76-100%) - Frequently (51-75%) - Occasionally (26-50%) - Intermittent (25% or less)

What other care have you received for your symptoms (including a Medical Doctor/Hospital, Physical Therapy, Therapeutic Massage, Personal Trainer, Acupuncture, another Chiropractor, etc.)? Was it helpful?

_____

_____

How has your symptoms limited your abilities (what has your symptoms prevented you from doing)?

_____

Please let us know if you have experienced any of the following (please circle):

Persistent constipation/diarrhea - Urination problems (burning, pain or frequency) - Shortness of Breath

Persistent Headache - Rapid Weight Loss - Unexplained Fatigue - Back Pain With Fever - Nausea

Blurred Vision - Light Headedness or Fainting - Chest/Left Arm/Jaw Pain - Confusion or Difficulty Speaking