Quality Chiropractic
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Name_____ **Date**_____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRIMARY COMPLAINT

Area of Complaint: _____ Right Left Bilateral

When did your complaint begin? _____

Have you had this complaint previously? Y (how long ago) N

What happened to cause or re-aggravate your complaint?

Unknown Work Accident Auto Accident Sports Injury Other:_____

Have you received any recent treatment for this complaint? Y N

If yes, please list dates, treatment type, and doctor_____

Describe your pain: Achy Burning Dull Sharp Stiff Throbbing Stabbing Tightness Tingling

Is your pain: Mild Moderate Severe

Please rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is the pain: Constant Frequent Intermittent Occasional

Does the pain travel anywhere? _____

Have you experienced a change in any of the following since your symptoms began?

Bowel Function Bladder Function Sexual Function None

What time of the day does it feel worse: Morning Afternoon Evening While sleeping

What aggravates your pain? _____

What time of the day does it feel better: Morning Afternoon Evening While sleeping

What alleviates your pain? _____

Is there numbness? Y N Where: _____

Is there spasm? Y N Where: _____

Is there any weakness? Y N Where:_____

Is there swelling? Y N Where: _____

If your complaint involves headaches, please complete the following:

What is the location of your headaches: Front Side Back Sinus

What time of day does it feel worse: Morning Afternoon Evening While sleeping

How often do they occur: _____ times per: Hour Day Week Month

Please rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

What is the duration of your headaches: _____ Minutes Hours Constant

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR SECONDARY COMPLAINT

Area of Complaint: _____ Right Left Bilateral

When did your complaint begin? _____

Have you had this complaint previously? Y (how long ago) N

What happened to cause or re-aggravate your complaint?

Unknown Work Accident Auto Accident Sports Injury Other:_____

Have you received any recent treatment for this complaint? Y N

If yes, please list dates, treatment type, and doctor_____

Describe your pain: Achy Burning Dull Sharp Stiff Throbbing Tingling Burning Other

Is your pain: Mild Moderate Severe

Please rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is the pain: Constant Frequent Intermittent Occasional

Does the pain travel anywhere? _____

Have you experienced a change in any of the following since your symptoms began?

Bowel Function Bladder Function Sexual Function None

What time of the day does it feel worse: Morning Afternoon Evening While sleeping

What aggravates your pain? _____

What time of the day does it feel better: Morning Afternoon Evening While sleeping

What alleviates your pain? _____

Is there numbness? Y N Where: _____

Is there spasm? Y N Where: _____

Is there any weakness? Y N Where:_____

Is there swelling? Y N Where: _____

Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s).

Numbness	Pins & Needles	Burning	Aching	Stabbing
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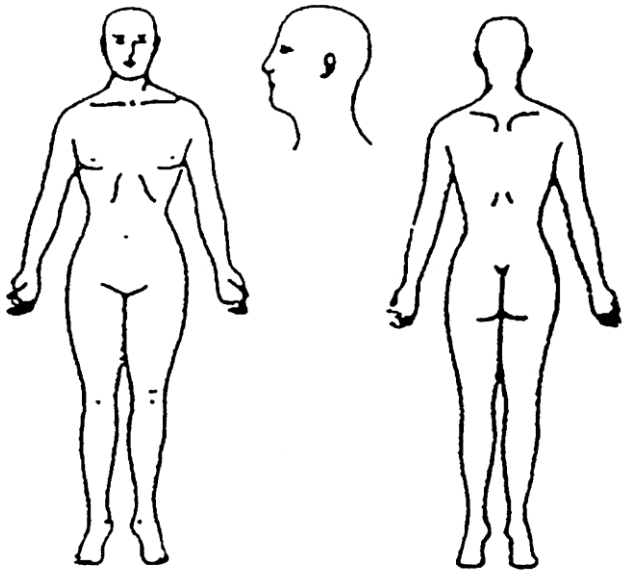

Please mark any of the following conditions or symptoms that you have now or have experienced previously:

- O **AIDS/HIV**
- O **Depression/Anxiety**
- O **Drug Abuse**
- O **Liver disease**
- O **Arthritis**
- O **Cancer**
- O **Hernia**
- O **Stroke**
- O **Insomnia**
- O **Digestion Problems**
- O **TB**
- O **Asthma**
- O **Diabetes**
- O **Thyroid disease**
- O **Kidney disease**
- O **Chest pain**
- O **Infections**
- O **Jaw pain/TMJ**
- O **Dizziness**
- O **Eye/ear disorder**
- O **Prostate problems**
- O **High blood pressure**
- O **Heart disease**
- O **Weight loss/gain**
- O **Polio**
- O **Sinus condition**
- O **Anemia**

Please complete the following regarding medications/supplements that you are currently taking.

Date Started	Vitamin/Drug Name	Prescribed by

Please list any allergies.

Allergy	Reaction

Please list any surgeries.

Date (Approximate)	Surgery	Facility

Please list hospitalizations (you can exclude surgery related if listed above.)

Date (Approximate)	Reason	Hospital

Please list any pertinent family history.

Relationship	History	Deceased Y/N	Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Paternal Grandparent			
Maternal Grandparent			

With whom do you currently live with: Alone Spouse Spouse/Children(#) Other

Smoking Status: Current Former Never

Alcohol Intake: None Casual Moderate Severe

Caffeine Intake: None <3/day 3 to 6/day >6/day

Recreational Drugs: None Recreational User Addict

Exercise Frequency: None Daily 3-6x/week 1-2x/week

Exercise Type: _____

Are you currently: In School Employed (FT or PT) Unemployed Retired

What is your occupation? _____

How long have you been at your current job? _____

Do you currently have a Primary Care Physician? Y N

Doctor's Name: _____

Have you been to a chiropractor prior to today's visit? Y N

Date of your last chiropractic adjustment: _____

Females: to the best of your knowledge are you pregnant? Y N

Date of last menstrual period: _____

To the best of my knowledge, all of the information completed above is correct.

Signature: _____ **Date:** _____