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?

<table>
<thead>
<tr>
<th>Bowel Function</th>
<th>Bladder Function</th>
<th>Sexual Function</th>
<th>None</th>
</tr>
</thead>
</table>

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  Tingling  Burning  Aching  Stabbing
----------  00000000000  ^^^^^^^  XXXXX  """"""""""""""""""""""""""""""

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

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

Please complete the following regarding medications/supplements that you are currently taking. If none of the above please write N/A

<table>
<thead>
<tr>
<th>Date Started</th>
<th>Vitamin/Drug Name</th>
<th>Prescribed by</th>
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<tbody>
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</tbody>
</table>

3
Please list any allergies. If none of the above please write N/A

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Please list any surgeries. If none of the above please write N/A

<table>
<thead>
<tr>
<th>Date (Approximate)</th>
<th>Surgery</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Please list hospitalizations, you can exclude surgery related if listed above. If none of the above please write N/A

<table>
<thead>
<tr>
<th>Date (Approximate)</th>
<th>Reason</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Please list any pertinent family history.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>History</th>
<th>Deceased Y/N</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
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<td></td>
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<tr>
<td>Sisters</td>
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<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandparent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandparent</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**With whom do you currently live with:**

<table>
<thead>
<tr>
<th></th>
<th>Alone</th>
<th>Spouse</th>
<th>Spouse/Children(#)</th>
<th>Other</th>
</tr>
</thead>
</table>

**Smoking Status:**
- Never
- Current: Every day smoker
- Current: Some days smoker
- Former

**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:**
________________________________________________________________________

**FEMALE:**

**To the best of your knowledge are you pregnant?**
- Y
- N

**Date of last menstrual period:**
________________________________________________________________________

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

**Signature:** ____________________________  **Date:** __________