

Name: _____ Date _____

What activities make your symptoms worse: _____

What activities make your symptoms better? _____

Who have you seen for your symptoms: _____

(1) No one ____ (2) Other Chiropractor ____ (3) Medical Doctor ____ (4) Physical Therapist ____ (5) Other ____

When and what treatment? _____

What tests have you had for your symptoms? (1) X-Rays/date: _____ (3) CT Scan/date: _____

Where? _____ (2) MRI/date: _____ (4) Other/date: _____

Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see? _____

_____ (1) This office ____ (3) Medical Doctor ____ (5) Other ____

_____ (2) Other Chiropractor ____ (4) Physical Therapist ____

What is your occupation? _____

General Questions:

Headaches: Y N Right side? Left side? Where? _____

Neck pain? Y N With back pains? Y N

Stomach pain? Y N _____

Arm pain? Y N Left? Right? _____

Leg Pain? Y N Left? Right? _____

Do you sleep on your: side? _____ stomach? _____ back? _____

Do you use pillow(s)? Y N How many? _____ What type? _____

Prior History:

Please list any and all fractures, giving date, how the fractures occurred and if it was casted: _____

Any and all surgeries giving date and reason: _____

Any auto accidents and/or bad falls? _____

Systemic illness such as Diabetes, heart Attack, High Blood Pressure _____

What do you hope to get from your visit/treatment (select all that apply):

- (1) reduced symptoms
- (2) explanation of condition/treatment
- (3) resume/increase activity
- (4) learn how to take care of this on my own
- (5) how to prevent this from occurring again
- (6) _____