

Name _____ Birthdate _____ Date _____

1. Describe your symptoms: _____
 - a. When did your symptoms start? _____
 - b. What caused your symptoms to begin? _____
2. How often do you experience your symptoms? _____

_____ Constantly (76 – 100% of the day)

_____ Frequently (51-75% of the day)

_____ Occasionally (26 – 50% of the day)

_____ Intermittently (0 – 25% of the day)
3. What describes the nature of your symptoms?

_____ sharp _____ shooting _____ stiff/sore

_____ dull ache _____ burning _____ tense/tight
4. How are your symptoms changing?

_____ getting better _____ not changing _____ getting worse

What makes your symptoms worse? _____

What makes your symptoms better? _____
5. Circle the lowest AND highest levels of your symptoms: (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
 - a. Are you pregnant? Yes No Not sure
 - b. Are you currently on any medications or supplements? List them please.

 - c. Do you smoke? Yes No Previously
 - d. Allergies: Environmental? _____

Medications? _____

Food? _____
 - e. Do you drink alcohol, coffee, or pop? If so, how many per day? _____
6. Who have you seen for your symptoms?

_____ No one _____ chiropractor _____ medical doctor _____ physical therapist _____ other
7. Have you had similar symptoms in the past? Yes No

If you received treatment in the past for similar symptoms, who did you see?

_____ this office _____ other chiropractor _____ medical doctor _____ P. T. _____ other
8. Do you have any other health problems such as.....

_____ Heart or blood pressure problems _____ gastrointestinal problems _____ organ (liver, kidney, etc.) problems

_____ urinary _____ musculoskeletal _____ arthritis

_____ eye, ear, nose, throat _____ respiratory/lungs _____ other health concerns/problems

_____ Unusual bleeding _____ Unexplained Weight Loss or Gain _____ Extreme Fatigue

If you checked any of these, please explain: _____

9. Do you have family members that have any of the following health concerns? M= Mother, F= Father, S= Sibling.

1.Arthritis _____	2. Osteoporosis _____
3. High blood pressure _____	4.Stroke _____
5. Heart Attack _____	6.Diabetes _____
7.Cancer _____	What kind? _____
8.Back Problems _____	What kind of problem? _____
10. Type of care desired: _____ Corrective _____ Symptom Relief

Signature _____ Date _____