

DATE: \_\_\_\_\_  
ACCT: \_\_\_\_\_

PATIENT: \_\_\_\_\_

# PATIENT HISTORY

1. What is your **main complaint**? \_\_\_\_\_
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

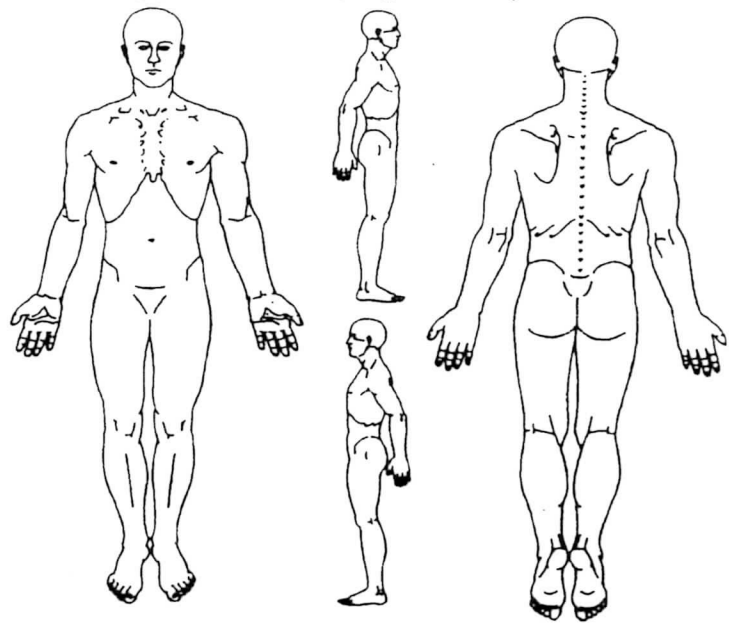
None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			Intermittent			Frequent			Constant		
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint**? \_\_\_\_\_
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

**A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care \_\_\_\_\_

lifting \_\_\_\_\_

reading \_\_\_\_\_

concentrating \_\_\_\_\_

work \_\_\_\_\_

driving \_\_\_\_\_

sleeping \_\_\_\_\_

recreation \_\_\_\_\_

walking \_\_\_\_\_

sitting \_\_\_\_\_

standing \_\_\_\_\_

social life \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

6. When do you notice it most?  AM  PM  
How long does it last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs
7. What makes it feel better? \_\_\_\_\_
8. What makes it feel worse? \_\_\_\_\_
9. Have you ever had this problem in the past?  Yes  No
10. I have  been hospitalized  been treated by another chiropractor  
 been treated by another specialty provider  never received care for this problem.
11. Have you lost time from work because of it?  Yes  No  
Dates? \_\_\_\_\_ to \_\_\_\_\_
12. Are you Pregnant?  Yes  No
13. What was the first day of your last menstrual cycle? \_\_\_\_\_
14. Number of pregnancies? \_\_\_\_\_ Miscarriages? \_\_\_\_\_