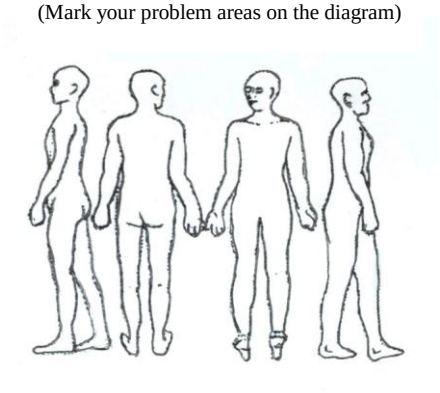
Patient's Condition Description / Health History

Patient Name: _____ Date: _____

(Mark your problem areas on the diagram)



Describe your condition or complaint: _____

_____

_____

_____

When did these symptoms begin? _____

What do you think caused this condition? _____

_____

Have you ever seen a chiropractor before? YES / NO If yes, when_____

What treatment was given and did it help? _____

_____

Do you think this may be a work related injury? **YES/NO** explain:	Could this be the result of an auto accident? **YES/NO** explain:

#1. Is your current condition: A) getting worse B) remaining constant C) coming and going

#2. Is your condition affecting: A) your work B) your ability to sleep C) your daily activities

#3. Are you feeling any: A) numbness B) tingling C) cramping D) dizziness E) weakness

If yes, where: _____

#4. Rate your pain level (scaled 1 to 10) **mild pain** 1 2 3 4 5 6 7 8 9 10 **severe pain**

#5. What is the frequency of the pain _____

#6. Describe the nature of the pain (dull, sharp, burning, etc.) _____

#7. What seems to relieve this condition? _____

#8. What seems to aggravate this condition? _____

(check all that apply)

Musculoskeletal

- o Low back pain
- o Mid back pain
- o Pain between shoulders
- o Neck pain
- o Arm problems
- o Leg problems
- o Swollen joints
- o Painful joints
- o Stiff joints
- o Sore muscles
- o Weak muscles
- o Walking problems
- o Spasms
- o TMJ / Jaw problems
- o Shoulder pain

Nervous System

- o Numbness
- o Loss of feeling
- o Paralysis
- o Dizziness
- o Fainting
- o Headaches
- o Muscle jerking
- o Seizures
- o Loss of coordination
- o Eye problems
- o Forgetfulness
- o Confusion
- o Depression
- o Insomnia

Cardio-Vascular

- o Chest pain
- o Pain over heart
- o Difficulty breathing
- o Persistent cough
- o Rapid heartbeat
- o Blood pressure problems
- o Heart problems
- o Lung problems
- o Varicose veins

Genito-Urinary System

- o Bladder trouble
- o Excessive urination
- o Scanty urination
- o Painful urination

Gastro-Intestinal

- o Poor appetite
- o Excessive hunger
- o Difficulty chewing
- o Difficulty swallowing
- o Excessive thirst
- o Nausea
- o Vomiting
- o Abdominal pain
- o Diarrhea
- o Constipation
- o Black stool
- o Bloody stool
- o Liver trouble
- o Gall bladder problems

Habits

- o Cigarettes and tabacco
- o Alcohol use
- o Drug use
- o Coffee or Tea

Are you currently being treated for any of the following conditions

o AIDS	o Tumors	o Osteoporosis	o Heart disease
o Cancer	o Diabetes	o Scoliosis	o Heart attack/stroke
o Polio	o Arthritis	o Multiple sclerosis	o Vascular disease
o Other _____			o High blood pressure

Are you or could you be pregnant? YES / NO

List any MAJOR SURGERIES you have had:____ _____

List all the MEDICATIONS you are taking: _____

List all AUTO accidents you have been in: _____