Date:___________

PATIENT MEDICAL INFORMATION

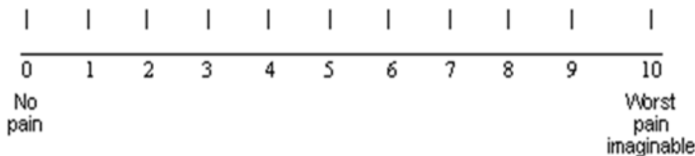
Name ____

Occupation ____

Current work status/duties ___________________________________

____

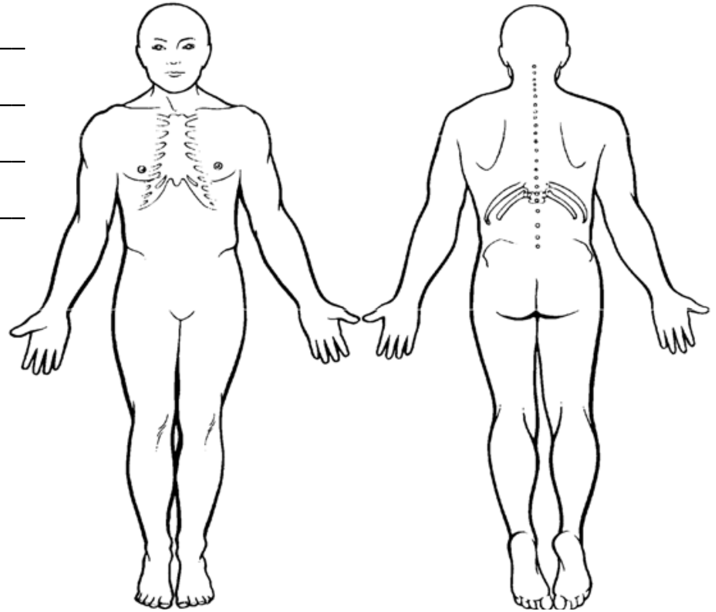
Use the scale below to answer the next 3 questions:



Your current level of pain while completing this survey ___/10

The best your pain has been in the past 48 hours ___/10

The worst your pain has been in the past 48 hours ___/10



Please mark the location(s) on the diagram where you are experiencing the problem(s) and describe the symptoms (i.e. sharp, dull, achy, deep, shooting, etc).

History of Current Condition

Give a brief description of the problem(s) for which you are seeking therapy: ____

____

When did this problem begin? ____

Treatment received so far for this problem (chiropractic, injections, etc.): ____

Have you ever had this problem before? Yes / No

If so, how was the problem treated?____

How often do you wake at night due to your symptoms? ____

My symptoms are currently (circle one): Getting Better Getting Worse The Same

Aggravating Factors: Identify up to 2 important positions and activities that make your symptoms worse:

1. ____

2. ____

Easing Factors: Identify up to 2 important positions or activities that make your symptoms better:

1. ____

2. ____

What are your goals for therapy? ____

____

PATIENT LABEL

Date:___________

Have you had any x-rays, CT scans, MRI, Bone Density scan, EMG, or Nerve Conduction study recently? Yes / No

If yes, when were the images taken and where? ____

Please list all current medications ____

____

Past Surgical History (list all & dates):

Surgical Procedure	Date

Currently I Am Experiencing: (circle all that apply)

Fatigue

Fever/Chills/Sweats

Nausea/Vomiting

Weight Gain/Loss

Difficulty Maintaining Balance with Walking

Falls

Numbness or Tingling

Muscle Weakness

Dizziness

Bowel and Bladder Changes

Shortness of Breath

Headaches

Fainting

Difficulty Swallowing

Heartburn/Indigestion

Medical History: Circle Each Condition That You Have Been Told You Have (or Had).

Cancer

Heart Disease

High Blood Pressure

Chest Pain/Angina

Circulatory Problems

Kidney Disease

Liver Disease

Lung Disease

Asthma

Diabetes

Stroke

Osteoporosis

Osteoarthritis

Rheumatoid Arthritis

Thyroid dysfunction

Bone/Joint Infection

Depression

Anemia

Fibromyalgia

Bladder infection

Other: ____

Please list any allergies that you have? ____

Do you have a pacemaker? Yes / No

Are you **currently** pregnant, or think you may be pregnant? Yes / No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes / No

During the past month, have you often been bothered by having little interest or pleasure in doing things? Yes / No

Is this something with which you would like help (circle one)? Yes Yes, but not today No