

PATIENT HISTORY

NAME _____ DATE _____

DATE OF BIRTH _____ SS# _____

CHIEF COMPLAINT: NECK PAIN HEADACHES MID-BACK LOW BACK ARM SHOULDER LEG OTHER
EXPLAIN _____

PAIN RADIATES: YES NO IF YES FROM _____ TO _____

ONSET: DATE _____ ONSET WAS: GRADUAL SUDDEN PROGRESSIVE OVER TIME

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAS THIS PROBLEM: IMPROVED REMAINED THE SAME WORSENERD ON AND OFF

IS THE COMPLAINT INJURY RELATED? YES NO WORK AUTO
EXPLAIN _____

MODE OF ONSET: POSITIONAL TRIP/FALL OTHER _____

SEVERITY OF PROBLEM: 1 2 3 4 5 6 7 8 9 10
(BEST) (WORST)

DURATION OF SYMPTOMS: INTERMITTENT (25% OF THE TIME) OCCASIONAL (25-50%)
FREQUENT (50-75%) CONSTANT (100%)

CHARACTER OF PAIN: DULL/ ACHE SHARP/ STABBING BURNING NUMBNESS/TINGLING
THROBBING OTHER(EXPLAIN) _____

HAS THIS PROBLEM AFFECTED: BOWEL OR BLADDER _____
OTHER BODY SYSTEMS (EXPLAIN) _____
NO APPERANT RELATIONSHIP

RELIEVING FACTORS: REST EXERCISE BRACING SITTING STANDING LYING DOWN HEAT COLD
OTHER: _____

AGGRAVATING FACTORS: COUGHING SNEEZING LIFTING BENDING PUSHING PULLING DRIVING
RIDING SITTING STANDING WALKING RUNNING OTHER _____

MEDICATIONS/SURGERIES _____

PREVIOUS INJURIES OR ACCIDENTS _____

HAVE YOU EVER BEEN TO A CHIROPRACTOR FOR THIS PROBLEM? YES NO

HAVE YOU EVER BEEN TO A CHIROPRACTOR FOR ANY OTHER PROBLEM? YES NO