MEDICAL HISTORY AND CHIEF COMPLAINT FORM

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Occupation: _____

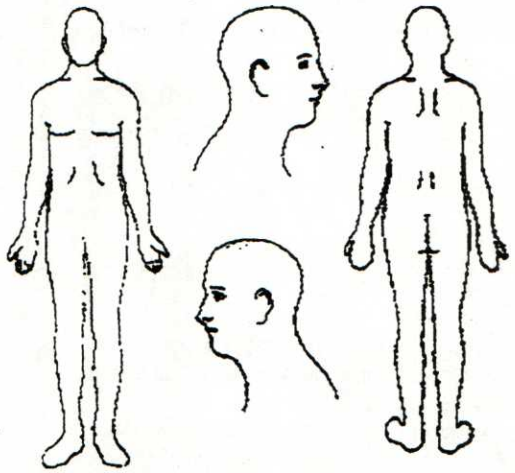
The following information is requested to assist the doctor in your chiropractic treatment .

What brought you here today? _____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Is this the first episode of this pain? _____ Yes _____ No

How long does pain last? (circle the one that applies) **Occasional, Frequent, Constant**

Does this pain travel to any other area? _____

What makes it feel better? _____

What makes it feel worse? _____

Have you done anything else to treat this complaint prior to your visit today? If Yes, what? _____

_____

What medications/supplements are you currently taking? _____

_____

Are you having any of the follow problems: (circle the ones that apply and how long you have had these problems: **Heart problems_____ High/Low Blood Pressure_____ Diabetes_____ Constipation _____ Headaches _____ Miscellaneous pain _____ Allergies (food or drug)_____**

Do drink alcohol? **Yes No** Do you smoke? **Yes No** Do you use recreational drugs? **Yes No**

Is this related to a **Work Comp** or **Liability Claim**? _____ Yes _____ No

If yes, who should be contacted regarding this visit? _____

_____

_____