

Patient Condition



Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? yes no

Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain).

1 2 3 4 5 6 7 8 9 10

Type of Pain: (Please circle all that apply)

Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? (Please circle) Daily Weekly Monthly Yearly

Is the pain constant? yes no Does the pain come and go? yes no

Does the pain interfere with: work sleep daily routine recreation

Activities or movements that are painful to perform:

sitting standing walking bending lying down driving

What treatments, if any, have you already received for your condition?

medical surgery physical therapy chiropractic other

Name of other doctor(s) who have treated you for your condition. _____

Please circle any of the following condition(s) that you have had:

AIDS/HIV	Cancer	Herniated Disc	Parkinson's Disease	Tumors
Alcoholism	Chemical Dependency	Herpes	Pinched Nerve	Ulcers
Allergy Shots	Diabetes	High Blood Pressure	Polio	Venereal Disease
Anemia	Emphysema	High Cholesterol	Prostate Problem	Whooping Cough
Anorexia	Epilepsy	Kidneys Disease	Prosthesis	
Appendicitis	Fracture	Liver Disease	Psychiatric Care	
Arthritis	Goiter	Migraine Headache	Rheumatoid Arthritis	
Asthma	Gout	Miscarriage	Stroke	
Bleeding Disorders	Heart Disease	Multiple Sclerosis	Suicide Attempt	
Breast Lump	Hepatitis	Osteoporosis	Thyroid Problem	
Bulimia	Hernia	Pacemaker	Tuberculosis	

EXERCISE

None
Moderate
Daily
Heavy

WORKACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

HABITS

Smoking
Alcohol
Coffee/Caffeine
High Stress

PREGNANT

Yes / No
Due Date:

INJURIES/SURGERIES YOU HAVE HAD:

LIST ALL CURRENT MEDICATIONS:

