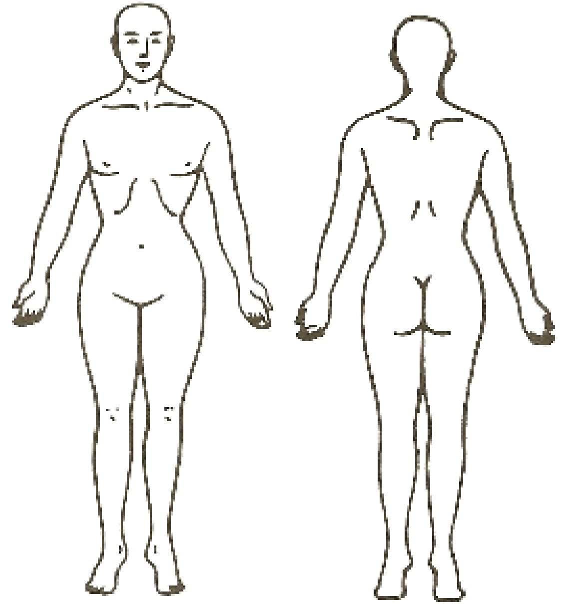
Please Mark your areas of pain on the figures shown below



Date:______________________________

PATIENT SYMPTOMS

Patient's Present Symptoms: __________________________

____

Additional Symptoms: _______________________________

____

Recent Falls: ________________________________ Recent Accidents: ____

Surgery Date: _______________ Other Illness: ____

Medication Being Taken: _____________________________________ Date of Last Physical: ______________________

First Chiropractic Treatment: [ ] Yes [ ] No

Patient Comments: ____

____

Check Symptoms You Have Noticed:

[ ] Headache [ ] Dizziness [ ] Light Hurt Eyes [ ] Diarrhea [ ] Head seems Heavy [ ] Memory Loss

[ ] Neck Pain [ ] Feet Cold [ ] Hands Cold [ ] Ears Ring [ ] Pins/ Needles – Arms [ ] Stomach Upset

[ ] Neck Stiff [ ] Nervousness [ ] Face Flushed [ ] Buzzing Ear [ ] Pins/Needle – Leg [ ] Constipation

[ ] Back Pain [ ] Lack Sleep [ ] Loss of Balance [ ] Cold Sweats [ ] Numbness — Fingers [ ] Fainting

[ ] Tension [ ] Short Breath [ ] Loss of Smell [ ] Fever [ ] Numbness — Toes [ ] High Blood Pressure

[ ] Irritability [ ] Fatigue [ ] Loss of Taste [ ] Depression [ ] Chest Pain

Additional Symptoms Not Listed: ____

Patient's First Name:____________________________________ Last Name: ____________________________________