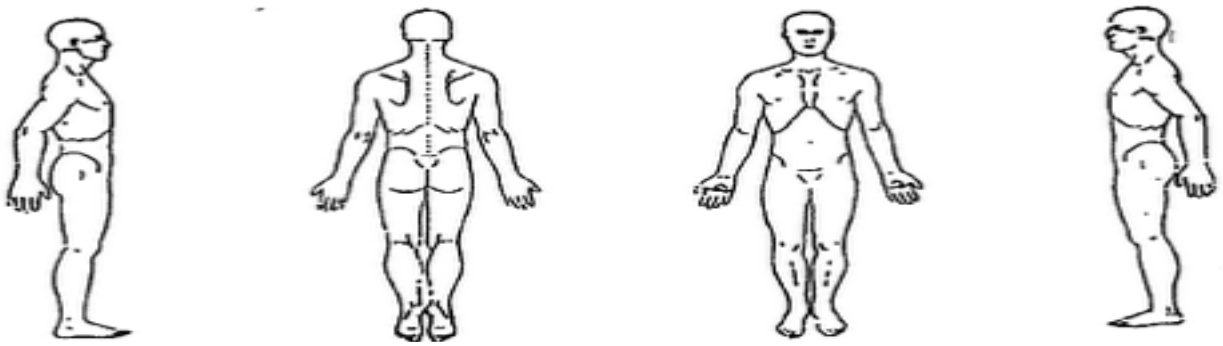
HOW MAY WE HELP YOU? PLEASE TELL US ABOUT YOUR SYMPTOMS page 1/2

HANDS OF LIGHT CHIROPRACTIC CARE

Date_____ Name_____DOB:_____

*What are your current symptoms_____



PLEASE MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

What caused/causes your symptoms?_____

Are they due to a *Work Injury (past present employer?)_____ *Auto Accident _____ *Other Accident _____
Please circle,if applicable, and give date.

*When did your symptoms begin? Give a date if possible._____

PLEASE CHECK OR CIRCLE RESPONSES TO THE QUESTIONS BELOW WHICH BEST DESCRIBE YOUR SYMPTOMS:

How did your symptoms begin?

Gradually Suddenly Off and on then suddenly worse- When?_____ Chronic problem

*Have you ever had the same condition before? No Yes - give date(s)_____

It has been a problem for _____weeks/months/years

How are your daily activities affected? No effect Some physical restrictions Unable to Exercise Unable to perform work/duties

*Dates you have missed work/school due to current symptoms: None _____

What would you like to be able to do when you feel better that you can't do now?_____

Describe the nature of your current symptoms._____

Use the checklist if it helps you:

Annoying Sore Dull Ache Stiff/Tight Deep Tender to touch Sharp with movement Swollen Stabbing Spasm

Burning Shooting Radiating/Referring Weak Throbbing Tingling Numb Dizziness Headache Loss of balance

Intensity of your symptoms: Minimal Mild Moderate Severe/Excruciating/Agonizing Increasing Decreasing Not changing

How frequent? Intermittent: 0-25% of the time Occasional: 25-50% Frequent: 50-75% Constant: 75-100% Other_____

I feel worse when I: _Rest _Sit _Get up from sitting _Ride in a car _Stand _Walk _Run _Lift _Bend _Twist Other_____ _Nothing Makes it worse

Time of day I feel worse: _No particular time _Waking up _Getting out of bed _Mid-Morning _Mid-day _Evening

_During the night _Fine in the morning and worse as the day goes on _Worse in the morning and fine once I get up/move

I feel better when I: _Rest _Move _Sit _Stand _Walk _Exercise/Stretch _Run Other_____ _Nothing helps

Affect of symptoms on sleep:

_None _Can't get comfortable _Pain wakes me up _Pain gets me out of bed _I am seriously sleep deprived due to symptoms

What treatments have you had for this? _None _Medication _Injections _Physical Therapy _Chiropractic care _Massage _Acupuncture _Ice _Heat _Surgery Other treatments_____ Star those which help the most

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 NAME:_____ DATE:_____

Do you have loss of bowel or bladder function? _None _Constipation _Unable to empty bladder _Loss of control: _bowel_bladder

Any recent fever/chills? _No _Yes Night sweats? _No _Yes Fatigue? _No _Yes

Unintended Weight Loss? _No Yes:____lbs

Is there anyone who hits or physically harms you? _No _Yes _Currently _In the past

Date of last visit with your Primary Care MD_____ Reason_____

*Have you had any tests or scans for this condition?No Yes: X-rays MRI CT scan Other _____

What area of body?_____

*Date: _____Facility: _____Findings:_____

Do you smoke? _Never Smoker _ Former Smoker (when Did you quit?_____)

_Yes _____per day For how long? _____months/years

How often do you consume alcohol? _Never _Rarely _Weekly _Daily _Amount_____

How often do you exercise?_____ What kind of exercise do you do?_____

What other health concerns do you have today?_____