Welcome!

NEW PATIENT

Name: _____ Date: _____

Tell me about your NECK:

☐ I have no pain or dysfunction in my neck. (move down to next area)

If you have neck pain… Have you had similar in past? ☐No ☐Yes What date did this episode start? _____

How often now? ☐ Rare (10%) ☐ Occasional (25%) ☐ Intermittent (50%) ☐ Frequent (75%) ☐ Constant (100%)

Please rate your neck pain: (least) 1 2 3 4 5 6 7 8 9 10 (take me to the ER)

Does your pain travel into your arms or hands? ☐ No ☐ Yes If yes…which side? ☐ Right ☐ Left

Do you have numbness or tingling in your arms or hands? ☐No ☐Yes If yes…which side? ☐ Right ☐ Left

Do your arms or hands feel noticeably weaker? ☐ No ☐ Yes

Tell me about your MID-BACK (between the shoulders):

☐ I have no pain or dysfunction in my mid-back. (move down to next area)

If you have mid-back pain… Have you had similar in past? ☐No ☐Yes What date did this episode start? _____

How often now? ☐ Rare (10%) ☐ Occasional (25%) ☐ Intermittent (50%) ☐ Frequent (75%) ☐ Constant (100%)

Please rate your middle back pain: (least) 1 2 3 4 5 6 7 8 9 10 (take me to the ER)

Does your pain wrap around the front of your body? ☐ No ☐ Yes If yes…which side? ☐ Right ☐ Left

Does the pain increase when you take a breath in? ☐No ☐ Yes

Tell me about your LOW BACK:

☐ I have no pain or dysfunction in my low back. (move down to next area)

If you have low back pain… Have you had similar in past? ☐No ☐Yes What date did this episode start? _____

How often now? ☐ Rare (10%) ☐ Occasional (25%) ☐ Intermittent (50%) ☐ Frequent (75%) ☐ Constant (100%)

Please rate your low back pain: (least) 1 2 3 4 5 6 7 8 9 10 (take me to the ER)

Does your pain travel into your legs? ☐ No ☐ Yes If yes…which side? ☐ Right ☐ Left

Do you have numbness or tingling in your legs or feet? ☐ No ☐ Yes If yes…which side? ☐ Right ☐ Left

Do your legs feel noticeably weaker or are you tripping often? ☐ No ☐ Yes

Where else are you feeling symptoms?

☐ I have no other symptoms.

If you do have other symptoms, tell me **where**: _____

How often? ☐ Rare (10%) ☐ Occasional (25%) ☐ Intermittent (50%) ☐ Frequent (75%) ☐ Constant (100%)

Please rate your pain: (least) 1 2 3 4 5 6 7 8 9 10 (take me to the ER)

Did you recently injure that part of your body? ☐ No ☐Yes

What parts of your life are being affected by your symptoms? (circle)

☐ **None**

Walking	**Sitting**	**Reading**	**Working**	**Driving**	**Gym**	**Showering**	**Sex**	**Sleeping**
Jogging	**Standing**	**Shaving**	**Bending**	**Dressing**	**Swimming**	**Dishes**	**Chores**	**Gardening**

Patient Signature: _____

I attest that the above is true and correct:

Chiropractic Care Centre
www.PainResults.com

Patient Name: _____

Have you seen a Chiropractor before? ☐ No ☐ Yes If yes… How long has it been? _____

Did they take before and after x-rays? ☐ No ☐ Yes

List any major surgery or injuries and year of each:_____

_____

Are you taking medication currently? ☐ None ☐ Anti-Inflammatory (Aspirin, Motrin, Advil etc)
☐ Tranquilizers ☐ Birth Control Pills ☐ Muscle Relaxers ☐ Pain Killers

List others:_____

Check all that apply to you (now or in the past): ☐ No Previous Major Illness or Condition

☐ Arthritis	☐ Cancer	☐ Ulcer	☐ Bone Fracture	☐ Tuberculosis
☐ Asthma	☐ High Blood Pressure	☐ Prostate Trouble	☐ Thyroid Trouble	☐ Diabetes
☐ Sinus Trouble	☐ Low Blood Pressure	☐ Osteoporosis/penia	☐ Spinal Disc Disease	☐ HIV/AIDS
☐ Allergies	☐ Heart Trouble	☐ Epilepsy	☐ Multiple Sclerosis	☐ OTHER Tell Doctor

Review of Systems:

GENERAL ☐ Normal

☐ Weakness ☐ Unusual Weight Change
☐ Fever ☐ Night Sweats
☐ Chills ☐ Fatigue
☐ Other

SKIN ☐ Normal

☐ Rash ☐ Eczema
☐ Redness ☐ Hair Changes
☐ Itching ☐ Nail Changes
☐ Other

NEUROLOGIC ☐ Normal

☐ Headache ☐ Fainting
☐ Dizziness ☐ Convulsions
☐ Other

EYES ☐ Normal

	Right	Left
Vision Trouble	☐	☐
Pain	☐	☐
Discharge	☐	☐
Other	☐	☐

EARS ☐ Normal

	Right	Left
Hearing Trouble	☐	☐
Ringing	☐	☐
Pain	☐	☐
Discharge	☐	☐
Other	☐	☐

NOSE ☐ Normal

☐ Pain ☐ Absence of Smell
☐ Bleeding ☐ Other

MOUTH/THROAT ☐ Normal

☐ Sores ☐ Absence of Taste
☐ Bleeding ☐ Abnormal Taste
☐ Other

HEART/LUNGS ☐ Normal

☐ Cough ☐ Blue Extremities
☐ Wheezing ☐ Murmur
☐ Difficulty Breathing ☐ Chest Pain
☐ Swollen Extremities ☐ Palpitations
☐ Other

BREASTS ☐ Normal

☐ Lumps in Breast(s) ☐ Dimpling
☐ Redness/Itching ☐ Discharge
☐ Pain ☐ Other

DIGESTIVE ☐ Normal

☐ Decreased Appetite ☐ Vomiting
☐ Increased Appetite ☐ Diarrhea
☐ Abdominal Pain ☐ Constipation
☐ Other

REPRODUCTIVE/URINATION ☐ Normal

☐ Inability to hold urine ☐ Impotence
☐ Painful Urination ☐ Sterility
☐ Frequent Urination ☐ Irregular Menstruation
☐ Painful Menstruation
☐ Abnormal Vaginal Bleeding
☐ Other

GLANDULAR ☐ Normal

☐ Heat/Cold Intolerance ☐ Goiter
☐ Sugar in Urine ☐ Tremor
☐ Other

MENTAL ☐ Normal

☐ Anxiety ☐ Phobias
☐ Depression ☐ Mood Swings
☐ Memory Loss or Impairment ☐ Other