Date:___________

# PATIENT MEDICAL INFORMATION

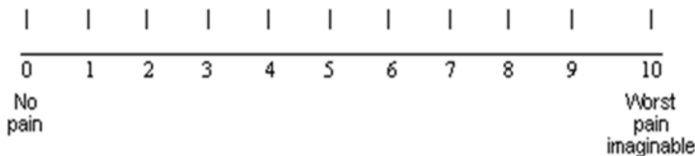
Name ____________________________________________________

Occupation ________________________________________________

Current work status/duties __________________________________

____________________________________________________________

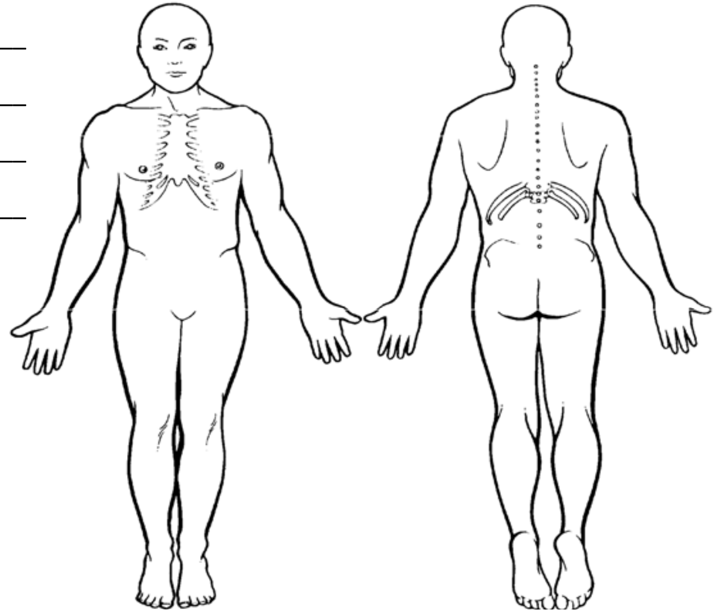
Use the scale below to answer the next 3 questions:




Your current level of pain while completing this survey ___/10

The best your pain has been in the past 48 hours ___/10

The worst your pain has been in the past 48 hours ___/10



Please mark the location(s) on the diagram where you are experiencing the problem(s) and describe the symptoms (i.e. sharp, dull, achy, deep, shooting, etc).

**History of Current Condition**

Give a brief description of the problem(s) for which you are seeking therapy: ______________________________

____________________________________________________________

When did this problem begin? ______________________________________________

Treatment received so far for this problem (chiropractic, injections, etc.): ______________________

Have you ever had this problem before? Yes / No

If so, how was the problem treated?______________________________________________

How often do you wake at night due to your symptoms? ______________________________

My symptoms are currently (circle one): Getting Better Getting Worse The Same

Aggravating Factors: Identify up to 2 important positions and activities that make your symptoms worse:

1. ____________________________________________________________

2. ____________________________________________________________

Easing Factors: Identify up to 2 important positions or activities that make your symptoms better:

1. ____________________________________________________________

2. ____________________________________________________________

What are your goals for therapy? ______________________________________________

____________________________________________________________



**PATIENT LABEL**

Date:___________

Have you had any x-rays, CT scans, MRI, Bone Density scan, EMG, or Nerve Conduction study recently? Yes / No

If yes, when were the images taken and where? ___________________________________________

Please list all current medications ___________________________________________

___________________________________________

**Past Surgical History (list all & dates):**

| Surgical Procedure | Date |
|---|---|
| | |
| | |
| | |
| | |

**Currently I Am Experiencing: (circle all that apply)**

| | | |
|---|---|---|
| Fatigue | Fever/Chills/Sweats | Nausea/Vomiting |
| Weight Gain/Loss | Difficulty Maintaining Balance with Walking | Falls |
| Numbness or Tingling | Muscle Weakness | Dizziness |
| Bowel and Bladder Changes | Shortness of Breath | Headaches |
| Fainting | Difficulty Swallowing | Heartburn/Indigestion |

**Medical History: Circle Each Condition That You Have Been Told You Have (or Had).**

| | | | | |
|---|---|---|---|---|
| Cancer | Heart Disease | High Blood Pressure | Chest Pain/Angina | Circulatory Problems |
| Kidney Disease | Liver Disease | Lung Disease | Asthma | Diabetes |
| Stroke | Osteoporosis | Osteoarthritis | Rheumatoid Arthritis | Thyroid dysfunction |
| Bone/Joint Infection | Depression | Anemia | Fibromyalgia | Bladder infection |

Other: ___________________________________________

Please list any allergies that you have? ___________________________________________

Do you have a pacemaker? Yes / No

Are you **currently** pregnant, or think you may be pregnant? Yes / No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes / No

During the past month, have you often been bothered by having little interest or pleasure in doing things? Yes / No

Is this something with which you would like help (circle one)? Yes Yes, but not today No