

Patient Name _____ Date _____

Patient Fill Out: 1 - 12

Doctor's Notes:

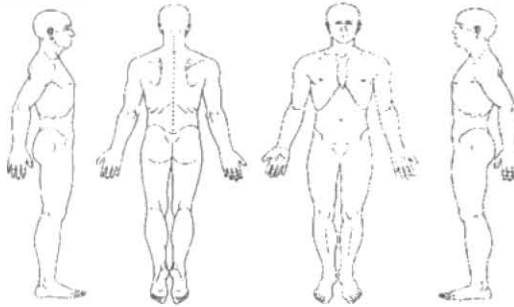
1. When did your symptoms start? _____
Describe your symptoms and how they began: _____

1. _____

2. How often do you experience your symptoms? **Indicate** where you have pain or other symptoms.

2. _____

- (1) Constantly (76 - 100% of the day)
- (2) Frequently (51 - 75% of the day)
- (3) Occasionally (26 - 50% of the day)
- (4) Intermittently (0 - 25% of the day)



3. What describes the nature of your symptoms?

3. _____

- (1) Sharp
- (2) Dull ache
- (3) Numb
- (4) Shooting
- (5) Burning
- (6) Tingling

4. How are your symptoms changing?

4. _____

- (1) Getting Better
- (2) Not Changing
- (3) Getting Worse

5. How bad are your symptoms at their:

5. _____

	None										Unbearable
a. worst	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
b. best	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

6. How do your symptoms affect your ability to perform daily activities?

6. _____

0:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
No complaints	Mild, forgotten with activity	Moderate, interferes with activity	Limiting, prevents full activity	Intense, preoccupied with seeking relief	Severe, no activity possible					

7. What activities make your symptoms worse? _____

7. _____

8. What activities make your symptoms better? _____

8. _____

9. Who have you seen for your symptoms? (1) No One (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

9. _____

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

- (1) X-rays date: _____ (3) CT Scan date: _____
- (2) MRI date: _____ (4) Other date: _____

10. Have you had similar symptoms in the past? (1) Yes (2) No

10. _____

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- (1) This Office (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

11. What is your occupation? _____

11. _____

- (1) Professional / Executive (3) Tradesperson (5) Homemaker (7) Retired
- (2) White Collar / Secretarial (4) Laborer (6) FT Student (8) Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- (1) Full-time (2) Part-time (3) Self-employed (4) Unemployed (5) Off work (6) Other

12. What do you hope to get from your visit / treatment (select all that apply):

12. _____

- (1) Reduce Symptoms (4) Learn how to take care of this on my own
- (2) Resume / increase activity (5) How to prevent this from occurring again
- (3) Explanation of condition / treatment (6) _____

Patient Signature _____ Date _____ Drs. Initials _____ Date _____

