FIRST VISIT SUBJECTIVE **DATE:** **Name:** **File #:**

1st Complaint: _____ DOO:_____

How this problem began: _____

Grade this complaint: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How often is this symptom present? circle 0-25% 26-50% 51-75% 76-100%

How much has this problem interfered with your daily activity?

Unable to perform 0 1 2 3 4 5 6 7 8 9 10 Completely able to perform

What makes this complaint feel better? _____

What makes this complaint feel worse? _____

2nd Complaint: _____ DOO:_____

How this problem began: _____

Grade this complaint: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How often is this symptom present? circle 0-25% 26-50% 51-75% 76-100%

How much has this problem interfered with your daily activity?

Unable to perform 0 1 2 3 4 5 6 7 8 9 10 Completely able to perform

What makes this complaint feel better? _____

What makes this complaint feel worse? _____

3rd Complaint: _____ DOO:_____

How this problem began: _____

Grade this complaint: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How often is this symptom present? circle 0-25% 26-50% 51-75% 76-100%

How much has this problem interfered with your daily activity?

Unable to perform 0 1 2 3 4 5 6 7 8 9 10 Completely able to perform

What makes this complaint feel better? _____

What makes this complaint feel worse? _____

4th Complaint: _____ DOO:_____

How this problem began: _____

Grade this complaint: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How often is this symptom present? circle 0-25% 26-50% 51-75% 76-100%

How much has this problem interfered with your daily activity?

Unable to perform 0 1 2 3 4 5 6 7 8 9 10 Completely able to perform

What makes this complaint feel better? _____

What makes this complaint feel worse? _____

List other services you have received in an effort to feel better: _____

_____

Have you had any Spinal X-rays, MRI, CT scan for your area of complaint? Yes No

Date and where taken: _____

FIRST VISIT SUBJECTIVE **DATE:** **Name:** **File #:**

Please shade in the area of your complaint.

(Do Not Circle)

A= Aching

B= Burning

N=Numbness

P= Pins + Needles

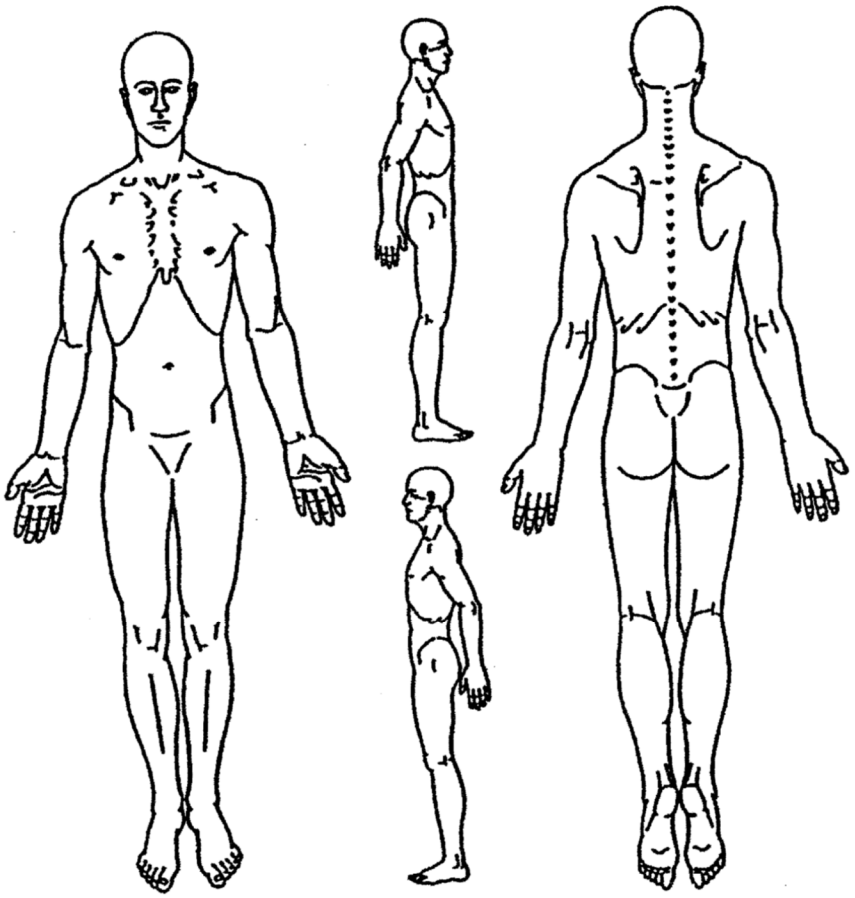
S= Stabbing

TH= Throbbing

SH= Shooting

SP= Spasms

O= Other



———-——-——-————————————-**OFFICE USE ONLY BELOW THIS LINE**————————————————————

Problem and Activity it is limiting				
1.				
2.				
3.				
4.				
Activity Scoring:				

Nutrition Date: _____ Re-Test: _____

Reflex	**Pulse**	**Supplement**	**Dose**	**Supplement**	**Dose**	**Supplement**	**Dose**

HEALTH HISTORY **DATE:** **Name:** **File #:**

Primary Care Physician: _____ Phone: _____

Address: _____

Is your primary care aware of your condition? Yes No Date of Last Primary Care Visit: _____

In general would you say your overall health is: Excellent Very good Good Fair Poor

Medications:_____

Vitamins: _____

Special diet or weight loss effort: _____

Exercise: _____

Currently Pregnant? No Yes # of weeks: _____

Cancer or Tumor: No Yes (Explain) _____

Surgeries: None or (Explain) _____

History of Alcohol or Drug Dependency? Y N _____

Tobacco History: None Use: _____

My work is sedentary **100% 75% 50% 25% 0%** of the time.

How long do you spend on your commute to work ? _____

Check all that apply:

__ Pain Unrelieved by Position or Rest

__ Numbness in the Groin/Buttocks

__ Recent Fever

__ High Blood Pressure

__ Stroke (date: _____)

__ Diabetes (Type I or II ?)

__ Corticosteroid Use (Cortisone, Prednisone etc.)

__ Birth Control _____

__ Dizziness or Fainting

__ Aids/HIV

__ Headaches not related to presenting complaint

__ Herniated or Slipped Disc (Neck Lower Back}

__ Prostate Problems

__ Menstrual Problems

__ Urinary Problems

__ Osteoporosis

__ Upper GI Problems

__ Lower GI Problems

__ Asthma

__ Epilepsy/Seizures

Other: _____

_____

Please report family history such as heart disease, cancer, stroke, diabetes etc. :

_____ deceased ___ _____deceased ___

_____ deceased ___ _____deceased ___

I certify to the best of my knowledge, the provided information is complete and accurate. If my health insurance information is not accurate, or if I an not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health insurance. I understand that my chiropractic physician may need to co-manage my treatment with my primary care physician. Therefore I give authorization to contact my physician if necessary.

Patient Signature: Date: