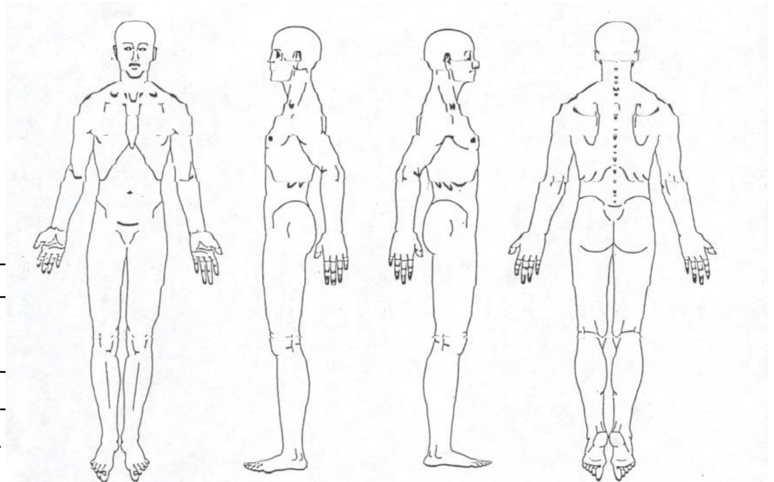
HEALING HANDS CHIROPRACTIC, PLLC

Patient Name (please print)____Date of Birth__________________

Indicate on this picture where you have pain or other symptoms.

(Please circle all areas of involvement)



Present Complaint/Reason for Seeking Care in this Office?
Major: ____
Pain or Problem started on? ___________________________
How did complaint occur?
____
____
____

How often do you experience your symptoms?

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

What describes the nature of your symptoms?

- ❒ Sharp
- ❒ Shooting
- ❒ Dull Ache
- ❒ Numb
- ❒ Burning
- ❒ Tingling

How are your symptoms changing?

- ❒ Getting Better
- ❒ Not Changing
- ❒ Getting Worse

What is the intensity of your symptoms?

	0	1	2	3	4	5	6	7	8	9	10
Worst	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Best	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Today	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒

What activities aggravate your condition/pain?____
What activities lessen your condition/pain?____
Is this condition worse during certain times of the day?______________________________________
Is this condition interfering with: Work?____________ Sleep?____________ Routine?____________ Other?_______________

Have you received treatments in the past for this similar symptom or complaint? Yes__________ No__________

Who/Where? ____

- ∆ This office
- ∆ Other Chiropractor
- ∆ Medical Doctor
- ∆ Physical Therapist

What Tests did you receive for your symptoms?
(Please Circle)
X-Rays
CT Scan
MRI Scan

** **Are your present symptoms or condition related to or the result of an auto accident, work related injury or other personal injury that someone else might be legally liable for? Yes _____ No _____** Your Initials __________

Patient or Guardian Signature____Date ___________________________

---OFFICE USE---

Height______________ Weight______________ Blood Pressure: Left____________________________ Right___________________________