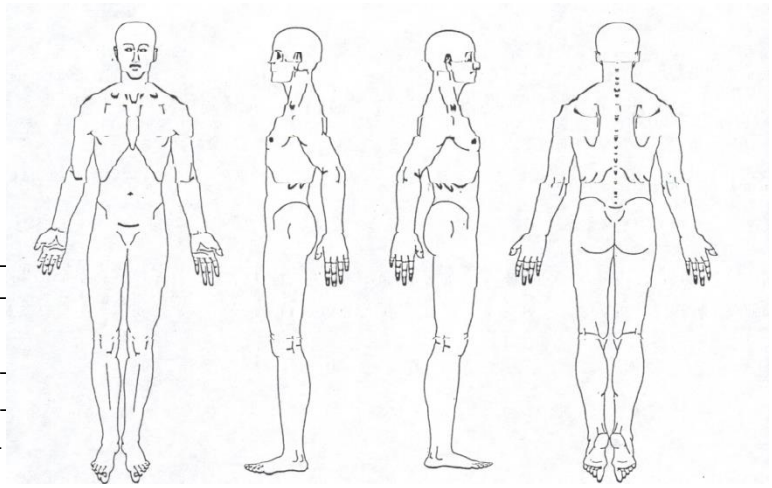
HEALING HANDS CHIROPRACTIC, PLLC

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 ❒ Numb
❒ Shooting ❒ Burning
❒ Dull Ache ❒ Tingling

How are your symptoms changing?

❒ Getting Better
❒ Not Changing
❒ Getting Worse

What is the intensity of your symptoms?

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