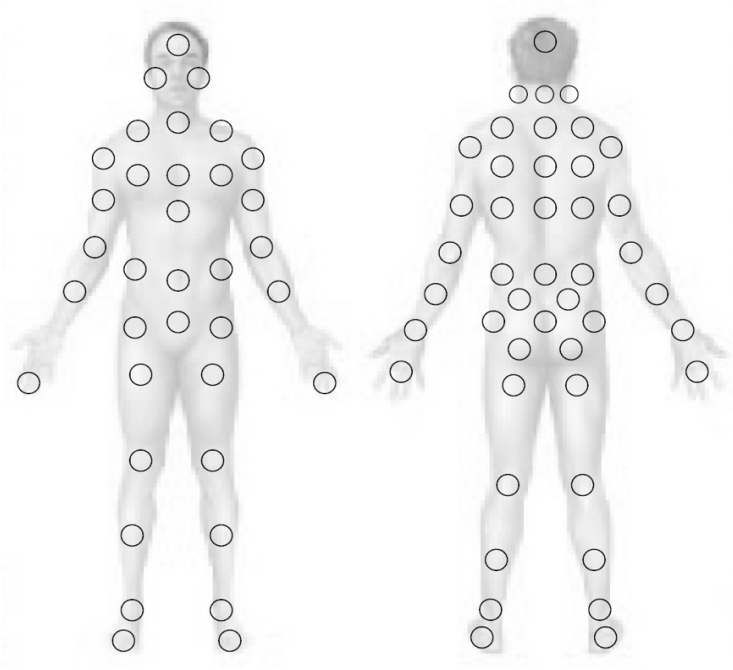
HISTORY OF COMPLAINT

Where is complaint? (Please mark on body diagram)



What was date of onset of this condition?_____

Mechanism of injury or condition?

☐Without a known origin ☐After a slip ☐After performing household chores ☐After sitting in one place too long
☐After a fall ☐After lifting an object(s)
☐After a long drive / flight ☐After overarching or reaching ☐After performing yardwork ☐After a prolonged or chronic illness
☐After a poor night's sleep
OTHER_____

Frequency of pain?

☐Constant (close to 100%) ☐Frequent (50-75%) ☐Occasional (25-50%) ☐Intermittent (less than 25%)
☐On and off ☐Random ☐Recurring

Quality of Pain? (Check all that apply)

☐dull ☐aching ☐annoying ☐burning ☐deep ☐heavy ☐discomfort ☐intolerable
☐pulling ☐sharp ☐"shock-like" ☐stabbing ☐"stiffness" ☐throbbing ☐"tightness" ☐tingle/numb

Does the pain radiate (travel) anywhere?_____

Since onset, complaint is ☐improved ☐stayed the same ☐worsened

What is the current pain level at its worst?

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Complaint relieved by:_____

Complaint aggravated by:_____

Have you had similar episodes in the past? Yes No

Previous or other care you've received for this complaint?_____

Recent diagnostic tests (X-ray, MRI, CT, etc.)?_____

Activities of daily living affected: (Check all that apply)

☐employment ☐homemaking ☐lifting ☐personal care (washing, dressing, etc.) ☐sitting
☐sleeping ☐social life ☐standing ☐traveling/driving ☐walking
☐OTHERS, more specific_____

How long can you do the above activities before the complaint starts?_____

REVIEW OF SYSTEMS

Please X or check appropriate boxes, if you had in the PAST and/or especially if you have NOW.

Musculoskeletal

☐No additional musculoskeletal complaints
☐Arthritis
☐Back problems
☐Cramping
☐Elbow/wrist pain
☐Foot/ankle pain
☐Fracture
☐Gout
☐Hip disorders
☐Implants or plates
☐Join or muscle pains/stiff
☐Knee injuries
☐Neck pain
☐Osteoporosis
☐Pins or screws
☐Poor posture
☐Scoliosis
☐Shoulder problems
☐Swelling, redness, deformity (joints)
☐TMJ issues

Neurological

☐No additional neurological complaints
☐Anxiety and/or panic
☐Depression
☐Difficulty concentrating
☐Dizziness
☐Epilepsy or seizures
☐Headache
☐Loss of smell or taste
☐Memory issues
☐Numbness
☐Pins and needles
☐Sleeping issues
☐Stroke
☐Temporary loss of vision, smells or hearing
☐Weak muscles

Head, Ears/Nose/Throat

☐No head and ENT complaints
☐Blurred or double vision
☐Cataracts
☐Changes in head dimensions
☐Chronic ear infections
☐Dental problems
☐Difficulty swallowing
☐Ear or hearing problems
☐Earache
☐Eye or vision problems
☐Eye surgery
☐Eyeglasses or contact lenses
☐Glaucoma
☐Gum problems
☐Headaches or migraines
☐Hoarseness
☐Nose / sinus congestion
☐Postnasal drip
☐Recent hearing loss
☐Ringing in the ears (tinnitus)
☐Sore throat
☐Swollen lymph nodes
☐TMJ problems

Cardiovascular

☐No cardiovascular complaints
☐Blood clots
☐Chest pain or tightness
☐Congenital heart defects
☐Coronary artery disease
☐Dizziness
☐Dyspnea
☐Excessive bruising
☐Heart attack
☐Heart murmur
☐High blood pressure
☐High cholesterol or triglycerides
☐Leg pain upon walking
☐Low blood pressure
☐Lower extremity edema
☐Palpitations
☐Rheumatic fever
☐Swollen legs or feet
☐Varicose veins

Respiratory

☐No respiratory complaints
☐Apnea
☐Asthma
☐Blood in sputum
☐Emphysema
☐Hay fever
☐Persistent cough
☐Pneumonia
☐Shortness of breath
☐Snoring issues
☐Tuberculosis
☐Wheezing

Gastrointestinal

☐No gastrointestinal complaints
☐Abdominal pain
☐Bloody or black stool
☐Bloating
☐Changes in bowel habits
☐Colitis
☐Colon cancer or colon polyps
☐Constipation
☐Crohn's Disease
☐Difficulty swallowing
☐Food sensitivities
☐Gastric reflux
☐Heartburn
☐Hemorrhoids
☐Irritable Bowel Syndrome
☐Jaundice
☐Liver disease
☐Nausea
☐Pancreatitis
☐Severe (or constant) diarrhea
☐Ulcer
☐Vomiting

Genitourinary

☐No genitourinary complaints
☐Blood in the urine
☐Incontinence
☐Kidney stones
☐Painful or frequent urination
☐Sexual dysfunction
☐Urgency urinary infections

PAST, FAMILY & SOCIAL HISTORY

Please X or check appropriate boxes

Endocrine

☐No endocrine complaints
☐Cushing's Syndrome
☐Diabetes
☐Excessive thirst
☐Feel hot or cold all the time
☐Heat or cold intolerance
☐Hyperparathyroidism
☐Hyperthyroidism
☐Hypothyroidism
☐Increase size of hands or feet
☐Increase urination
☐Pancreatic conditions
☐Polydipsia
☐Polyuria
☐Purple striae
☐Steroid treatments
☐Testosterone deficiency
☐Thyroid Problems

Dermatological or Hemopoietic

☐No dermatological or hemopoietic complaints
☐Blood in stool
☐Change in hair or nails
☐Easy bruising
☐Eczema
☐Excessive acne
☐Excessive hair loss
☐Flushing
☐Gum bleeding
☐Hyper/hypo-pigmentation
☐Psoriasis
☐Skin cancer
☐Skin pigmentation issues
☐Skin trouble or rashes

Exercise Routine

☐None
☐Daily
☐Often
☐Every other day
☐Few times a week
☐Once a week
☐Almost nothing
☐Sports_____
_____
☐Hobbies_____
_____

Allergies / Sensitivities

☐No allergies / sensitivities
☐Environmental
☐Animal dander / fur_____
☐Dairy
☐Dust
☐Latex
☐Nuts
☐Pollen
☐Seafood
☐Tape / Adhesive
☐Therapy cold sensitivity
☐Therapy heat sensitivity
☐What / Gluten
☐Medicinal_____
☐Anti-seizure meds
☐Cephalosporins
☐General anesthesia
☐IV contrast dye
☐Local anesthesia
☐NSAID's
☐Penicillin
☐Sulfonamides

Surgeries

☐Abdominal-aortic aneurysm repair
☐Appendectomy
☐Bunionectomy
☐C-Section
☐Cardiac bypass
☐Cardia Valve Replacement
☐Carpal Tunnel (L / R / B)
☐Cataract (L / R / B)
☐Cosmetic_____
_____
☐Discectomy (level_____)
☐Ear tubes
☐Gallbladder removed
☐Ganglion Cyst
☐Gastric Bypass
☐Hysterectomy (complete)
☐Hysterectomy (partial)
☐Implants
☐Knee replace (L / R / B)
☐Hip replace (L / R / B)
☐Lasik
☐Mastectomy
☐Shoulder (L / R / B)
☐Spinal fusion
☐Thyroidectomy
☐Tonsils
☐Tonsils & adenoids
☐Transplant_____
☐Wisdom teeth

Past Illnesses / History (SELF)

☐Number of children_____
☐Number of pregnancies_____
☐Number of deliveries_____
☐Cancer_____
☐Congenital anomaly_____
☐Hereditary disorder_____
☐Hospitalization_____
☐Trauma/injuries_____
☐Auto/vehicle accidents_____
☐Falls or other_____
☐Past fractures_____
☐AIDS/HIV
☐Alcoholism
☐Alzheimer's
☐Anemia
☐Anorexia
☐Arthritis
☐Asthma
☐Bleeding disorders
☐Breast lumps
☐Bronchitis
☐Bulimia
☐Chemical dependency
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy
☐Heart disease
☐Liver disease
☐Migraine headaches
☐Miscarriage
☐Multiple sclerosis
☐Natural labor(s)
☐Osteoarthritis
☐Osteoporosis
☐Pacemaker
☐Parkinson's disease
☐Pinched nerve
☐Pneumonia
☐Polio
☐Previous chiropractic care
☐Prostate proems
☐Psychiatric care
☐Rheumatoid arthritis
☐Stroke
☐Suicide attempt
☐Thyroid problems
☐Tumor
☐Ulcers
☐Vaginal infection
☐Venereal disease

PAST, FAMILY & SOCIAL HISTORY

Please X or check appropriate boxes

FAMILY History

☐None / Unsure
☐AIDS/HIV
☐Alcoholism
☐Alzheimer's
☐Anemia
☐Anorexia
☐Arthritis
☐Asthma
☐Bleeding disorders
☐Breast lumps
☐Bronchitis
☐Bulimia
☐Chemical dependency
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy
☐Heart disease
☐Liver disease
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☐Previous chiropractic care
☐Prostate proems
☐Psychiatric care
☐Rheumatoid arthritis
☐Stroke
☐Suicide attempt
☐Thyroid problems
☐Tumor
☐Ulcers
☐Vaginal infection
☐Venereal disease

Employment Status

☐Cannot work
☐Permanent fully disabled
☐Permanent partially disabled
☐Full-time
☐Part-time
☐Homemaker
☐Retired
☐Student
☐Unemployed
☐Mostly sitting
☐Mostly standing
☐Mostly walking
☐Light labor
☐Moderate labor
☐Heavy labor
☐Difficult
☐Enjoyable
☐Relaxed Stressful

Social Habits

☐Does NOT drink alcohol
☐Social drinker
☐Light drinker
☐Moderate drinker
☐Heavy drinker
☐Alcoholic
☐Recovering alcoholic
☐Current every day smoker
☐Current some days smoker
☐Ex-smoker
☐Heavy tobacco smoker
☐NEVER smoked tobacco
☐Does NOT drink coffee
☐Drink 1 cup of caffeine in AM
☐Drink 2 – 4 cups / day
☐Drink 5 or more cups / day
☐Diet Soda Drinker
☐Does NOT use recreational drugs
☐Light use of recreational drugs
☐Moderate use of recreational drugs
☐Heavy use of recreational drugs
☐Drug addicted
☐Recovering drug addict

Diet & Nutrition

☐Controlled
☐Out-of-control
☐Restricted
☐Unrestricted
☐1 – 2 meals a day
☐2 – 3 meals a day
☐More than 3 meals a day
☐Eating too little
☐Eating too much
☐Binges
☐Purges
☐Balanced
☐High protein
☐Low carbohydrate
☐Low fat
☐Low cholesterol
☐No red meat
☐Atkins
☐Diabetic
☐Gluten-free
☐Ideal Protein
☐Jenny Craig
☐Kosher
☐Macrobiotic
☐Paleo
☐Raw food
☐SouthBeach
☐Vegan
☐Vegetarian
☐Weight Watchers
☐Zone
☐Do NOT take supplements
☐Take daily supplements

Medications

☐None
☐Over-the-counter_____
_____
☐Prescription_____
_____
☐Anti-depressant
☐Muscle relaxes
☐NSAID / Pain relief
☐Steroidal anti-inflammatory
☐Anti-acid
☐Anti-viral
☐Aspirin
☐Chemotherapy
☐Codeine
☐OTHER_____