Quality Chiropractic
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(703)581-8999 • fax (703) 481-0396

Name___________________________________ **Date**_______________

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRIMARY COMPLAINT

Area of Complaint: ______________________________________ Right Left Bilateral

When did your complaint begin? ____

Have you had this complaint previously? Y (how long ago) N

What happened to cause or re-aggravate your complaint?

Unknown Work Accident Auto Accident Sports Injury Other:_____________

Have you received any recent treatment for this complaint? Y N

If yes, please list dates, treatment type, and doctor____

Describe your pain: Achy Burning Dull Sharp Stiff Throbbing Stabbing Tightness Tingling

Is your pain: Mild Moderate Severe

Please rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is the pain: Constant Frequent Intermittent Occasional

Does the pain travel anywhere? ____

Have you experienced a change in any of the following since your symptoms began?

Bowel Function Bladder Function Sexual Function None

What time of the day does it feel worse: Morning Afternoon Evening While sleeping

What aggravates your pain? ____

What time of the day does it feel better: Morning Afternoon Evening While sleeping

What alleviates your pain? ____

Is there numbness? Y N Where: ____

Is there spasm? Y N Where: ____

Is there any weakness? Y N Where:____

Is there swelling? Y N Where: ____

If your complaint involves headaches, please complete the following:

What is the location of your headaches: Front Side Back Sinus

What time of day does it feel worse: Morning Afternoon Evening While sleeping

How often do they occur: _______________ times per: Hour Day Week Month

Please rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

What is the duration of your headaches: _________________ Minutes Hours Constant

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR SECONDARY COMPLAINT

Area of Complaint: ____ Right Left Bilateral

When did your complaint begin? ____

Have you had this complaint previously? Y (how long ago) N

What happened to cause or re-aggravate your complaint?

Unknown Work Accident Auto Accident Sports Injury Other:_______________

Have you received any recent treatment for this complaint? Y N

If yes, please list dates, treatment type, and doctor_______________________________________

Describe your pain: Achy Burning Dull Sharp Stiff Throbbing Tingling Burning Other

Is your pain: Mild Moderate Severe

Please rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is the pain: Constant Frequent Intermittent Occasional

Does the pain travel anywhere? ____

Have you experienced a change in any of the following since your symptoms began?

Bowel Function Bladder Function Sexual Function None

What time of the day does it feel worse: Morning Afternoon Evening While sleeping

What aggravates your pain? ____

What time of the day does it feel better: Morning Afternoon Evening While sleeping

What alleviates your pain? ____

Is there numbness? Y N Where: ____

Is there spasm? Y N Where: ____

Is there any weakness? Y N Where:____

Is there swelling? Y N Where: ____

Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s).

Numbness	Tingling	Burning	Aching	Stabbing
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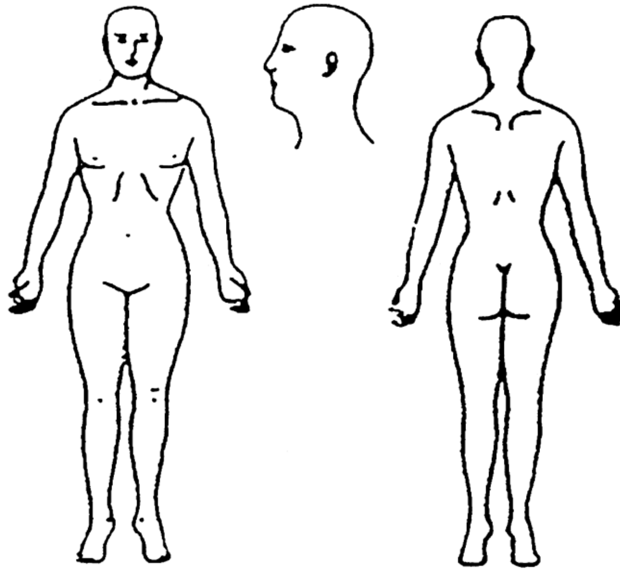

Please mark any of the following conditions or symptoms that you have now or have experienced previously:

O AIDS/HIV
O Depression/Anxiety
O Drug Abuse
O Liver disease
O Arthritis
O Cancer
O Hernia
O Stroke
O Insomnia
O Digestion Problems
O TB
O Asthma
O Diabetes
O Thyroid disease
O Kidney disease
O Chest pain
O Infections
O Jaw pain/TMJ
O Dizziness
O Eye/ear disorder
O Prostate problems
O High blood pressure
O Heart disease
O Weight loss/gain
O Polio
O Sinus condition
O Anemia

Please complete the following regarding medications/supplements that you are currently taking. If none of the above please write N/A

Date Started	Vitamin/Drug Name	Prescribed by

Please list any allergies. If none of the above please write N/A

Allergy	Reaction

Please list any surgeries. If none of the above please write N/A

Date (Approximate)	Surgery	Facility

Please list hospitalizations, you can exclude surgery related if listed above. If none of the above please write N/A

Date (Approximate)	Reason	Hospital

Please list any pertinent family history.

Relationship	History	Deceased Y/N	Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Paternal Grandparent			
Maternal Grandparent			

With whom do you currently live with: Alone Spouse Spouse/Children(#) Other

Smoking Status: Never Current: Every day smoker Current: Some days smoker Former

Alcohol Intake: None Casual Moderate Severe

Caffeine Intake: None <3/day 3 to 6/day >6/day

Recreational Drugs: None Recreational User Addict

Exercise Frequency: None Daily 3-6x/week 1-2x/week

Exercise Type: ____

Are you currently: In School Employed (FT or PT) Unemployed Retired

What is your occupation? ____

How long have you been at your current job? ____

Do you currently have a Primary Care Physician? Y N

Doctor's Name: ____

Have you been to a chiropractor prior to today's visit? Y N

Date of your last chiropractic adjustment: ____

FEMALE:

To the best of your knowledge are you pregnant? Y N

Date of last menstrual period: ___________________________

To the best of my knowledge, all of the information completed above is correct.

Signature: ____ **Date:** ______________