Name _____ Patient Update Date: _____

What is your Chief Complaint? _____Secondary Complaint_____

Is your pain Constant or does it Come and Go?

When did your symptoms / Complaint appear? _____

How did your condition Happen? _____

_____

_____

Has your condition: Gotten Worse Gotten Better Stayed The Same

What makes the pain / symptoms worse? Walking Going to/Sitting Going to/Standing Desk Work Lying Down Twisting/Turn Bending Lifting Driving Sports Ice/Heat Sleeping

Other _____

What makes the pain / symptoms better? Nothing Walking Sitting Standing Rest Cold / Heat over the counter Meds Prescription Meds Stretching Massage Bio Freeze Lying Down Twisting/Turn Bending Lifting Driving Sports Ice/Heat Sleeping

Other _____

What does the Pain / Symptoms feel like? Burning Cramps Dull/Achy Localized Sharp Stiffness Shooting Stabbing Throbbing Tightness Numbness/Tingling Other_____

Does the Pain travel? YES NO Where? _____

_____

Pain Level 1 (Best) 2 3 4 5 6 7 8 9 10 (Call the ambulance) WITH ACTIVITY WITH REST (Circle)

When do you have most of your pain? Morning Afternoon Evening While Sleeping ALL DAY

Have you ever seen a Chiropractor YES NO When and who? _____

Have you seen anyone else (MD, DO, Surgeon?) for this issue? _____

_____

Any Auto Accidents? YES NO When and brief description _____

_____

Falls or Injuries? YES NO Description _____

_____

Surgeries? YES NO Description _____

_____

Any other health Concerns? _____

_____

_____