Patient's Name: Doctor's Name: Date:

PRESENT COMPLAINT

Please give a detailed description of your condition (For example: I was bending over to pick up a box from the floor, and I felt immediate sharp pain in my left low back).

Please place an "X" on the line below to indicate your "pain status" today (see example).

Example: *Mid Back*

No Pain **Most Severe Pain**

Your pain today:

No Pain **Most Severe Pain**

DATE OF ONSET: / /

Please circle the progression of pain:
Better Worse Same

Please circle the description that best fits your condition:
Sharp Stabbing Burning Achy
Numbness/Tingling Dull Tight Stiff

Please circle the word that describes the pattern of your pain: Constant On/Off

Activities of Daily Living Questionnaire

Please check activities that cause pain:

O Sitting	O Sleeping	O Brushing Teeth
O Standing	O Pushing	O Lying on Stomach
O Walking	O Pulling	O Lying on back
O Bending	O Kneeling	O Dressing
O Lifting	O Climbing	O Washing

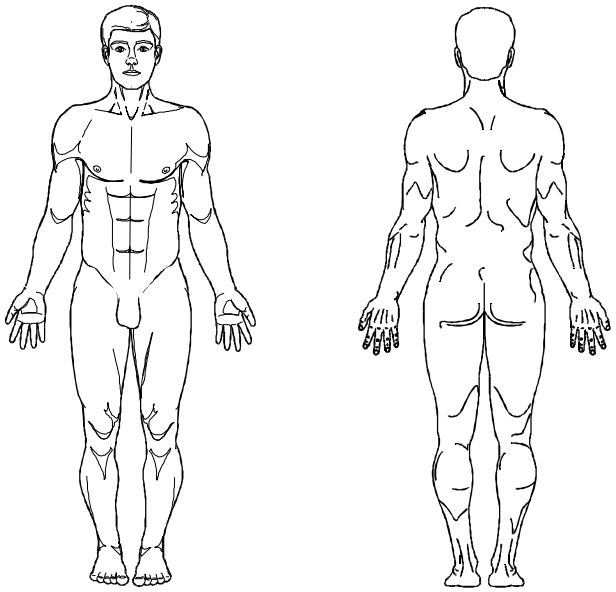
INSTRUCTIONS:

Please indicate on the pain diagram, using the symbols below, the area(s) where you feel pain.

Legend

Numbness	- - - - - - - -
Sharp	oooooooo
Stabbing	////////////////
Burning	XXXXXXXX
Achiness	AAAAAAAA
Tightness	TTTTTTTT

Pain Diagram



If 0% equaled the worst you could possibly feel, and 100% equaled the best you could possibly feel, please indicate (by circling) how you are feeling today: 0 5 10 20 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100 %

Have you seen another chiropractor or medical physician within the last (12) twelve months for this complaint, if so, when? / /

Along with you major complaint, do you also periodically have: (circle any that apply)
Headaches Neck Pain Mid-Back Pain Low-Back Pain Numbness/Tingling/Pain in Arms or Legs

Do you have, or have you had, any (tumors, bleeding disorders, diabetes, pacemaker, metallic implants, Blood pressure problems, AIDS, ARC or heart problems.) Please explain:

Please list ALL previous ACCIDENTS, SURGERIES, FRACTURES, or HOSPITALIZATIONS. (SEE EXAMPLE)

DATE	DETAILED DESCRIPTION
1/1/1992	*Left knee arthroscopic surgery*

Please list all MEDICATION(S) you are taking and for what CONDITION(S). (SEE EXAMPLE)

MEDICATION	CONDITION
Lopressor	*High blood pressure*

Please list the name(s) of your current PHYSICIAN(S) and CONDITION(S) you are seeing them for. (SEE EXAMPLE)

PHYSICIAN	CONDITION
Dr. J. Smith, M.D.	*High blood pressure/family doctor*

By my signature, I acknowledge that the above is true and accurate to the best of my knowledge

Patient's Signature Date