Initial Examination Form

Patient sticker

What is your **Main Complaint** today? ____

____

Explain **how** it occurred? ____

____

Date Problem began? ____________________________

Where did it occur? ☐ Home ☐ Work ☐ Automobile (If <u>work</u> or <u>automobile</u> please <u>stop</u> and see front desk)

On the following scale please circle the **intensity/severity** of your pain?

(no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

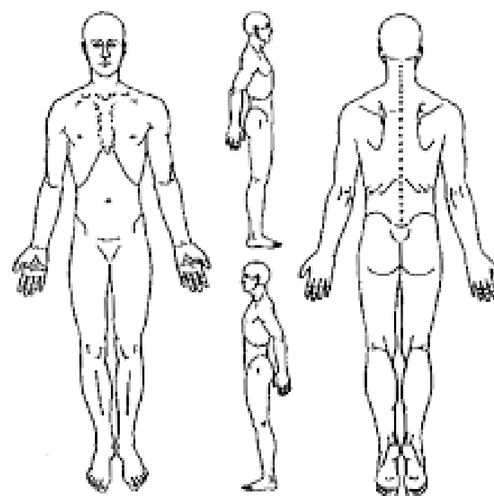
How often do you experience your symptoms? <u>Circle</u> one

a) Constantly (76-100% of the day) b) Frequently (51-75% of the day)
c) Occasionally (26-50% of the day) d) Intermittently (0-25% of the day)

Have you been **treated for this complain before**? ☐ Yes ☐ No

If yes, by **whom** and **when**? ____

On the figure to the right, <u>please mark</u> all areas of symptoms



Has your condition become **worse** since it started?

☐ Yes ☐ No

Describes what it feels like: ☐ Sharp ☐ Stabbing ☐ Dull ☐ Ache
☐ Tightness ☐ Pulling ☐ Throbbing ☐ Numbness ☐ Tingling
☐ Pins & Needles ☐ Pops
☐ Other: ____________________________

Do your symptoms **radiate** or shoot to other areas? ☐ Yes ☐ No

If yes, where to? ____________________________

List anything (activities, movements, medication, heat, ice) that makes your condition

Better? ____________________________ **Worse**? ____________________________

What activities are **not able to do** since the start of this problem?

____

Have you had any of the following happen to your back or neck?

Trauma ☐ Yes ☐ No Surgery ☐ Yes ☐ No Accidents ☐ Yes ☐ No

If yes, please explain: ____

Have you previously received care from another Doctor? ☐ Yes ☐ No

If yes, from **whom?** ____________________________ and **when**? ____________________________

Have you previously received Chiropractic Care? ☐ Yes ☐ No

If yes, from **whom?** ____________________________ and **when**? ____________________________

Please mark any of the following you have had **difficulty with**:

- ☐ Numbness in arms or hands
- ☐ Tingling in arms or hands
- ☐ Pain in arms or hands
- ☐ Numbness in legs or feet
- ☐ Tingling in legs or feet
- ☐ Pains in legs or feet
- ☐ Headaches
- ☐ Disc problems
- ☐ Joint swelling
- ☐ Painful joints
- ☐ Arthritis
- ☐ Chest pains
- ☐ Sinus problems
- ☐ Osteoporosis
- ☐ Swollen Ankles
- ☐ Masses/Growths/Lumps
- ☐ Pain that wakes you up at night
- ☐ Sleeping problems
- ☐ Stomach problems
- ☐ Kidney problems
- ☐ Bladder problems
- ☐ Frequent urination
- ☐ Gallbladder problems
- ☐ Cancer
- ☐ Lights bothers eyes
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Hernia
- ☐ Tumor
- ☐ Increased Stress
- ☐ Enlarged organ
- ☐ Stroke
- ☐ Ring/buzzing in ears
- ☐ Blurred or double vision
- ☐ Asthma
- ☐ Slurred speech or other speech problems
- ☐ Loss of consciousness or blackouts
- ☐ Difficulty Swallowing
- ☐ Loss of taste or smell
- ☐ Short of Breath
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Heart problems
- ☐ Leg Cramps
- ☐ Constipation
- ☐ Recent hearing loss in one or both ears
- ☐ Weakness, clumsiness or loss of strength in your face, fingers, hands, arms or legs
- ☐ Sudden collapse without loss of consciousness
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ Excessive fatigue
- ☐ Heart burn / GERD
- ☐ Pregnancy
- ☐ Bruising

☐ No difficulties

If any above are checked please explain: ______________________________

____

____

List **major illnesses requiring medical care or surgery** in the past five years:

____

Do you currently take any **Prescription Medication** ☐ No ☐ Yes If yes, please List:

____

Do you have any of the following conditions in your **family history** (check each that apply)

☐ Arthritis ☐ Heart disease ☐ High blood pressure ☐ Kidney disease ☐ Tuberculosis ☐ Thyroid disease

☐ Cancer (type): _______________ ☐ Other: ______________________

Have you had any **X-Rays / MRIs / CTs** ☐ Yes ☐ No If yes, at what part of the body? ____________________

What facility/Location? ________________________________ and Date? ______________________________

Social History

Do you smoke/vape/ or use chewing tobacco? ☐ No ☐ Yes If yes, list which product and how often

____

How active are you? ☐ I'm a couch potato ☐ I exercise regularly 3-4x/week

☐ I have a physically active/strenuous job, yet don't exercise regularly.

☐ I'm an exercise guru. I can't live without exercising every day.

☐ Other: ______________________________

How often do you consume alcoholic beverages? ______________________________

PATIENT STOP HERE