

Patient Name: _____

PAST AND PRESENT GENERAL HEALTH HISTORY (Page 2)

CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper back pain, soreness, or stiffness	
<input type="checkbox"/> Neck pain, soreness, or stiffness		<input type="checkbox"/> Hip pain	
<input type="checkbox"/> Low back pain, soreness, stiffness		<input type="checkbox"/> Leg or foot pain, numbness, or tingling	
<input type="checkbox"/> Arm/Hand pain, numbness, or tingling		<input type="checkbox"/> Other:	

WHAT SYMPTOM PRIMARILY BOTHERS YOU? _____

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describe how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition? No Yes

If yes, Chiropractors Name: _____ Year: _____

Problem treated for: _____

ARE YOU TAKING ANY MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Anacin
<input type="checkbox"/> Anti-Inflammatory	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Bufferin
<input type="checkbox"/> Narcotics for Pain	<input type="checkbox"/> Advil/Motrin	<input type="checkbox"/> Stroke Prevention Meds
<input type="checkbox"/> Heart Medications	<input type="checkbox"/> Birth Control Medications	<input type="checkbox"/> Other

WHEN IS YOUR PAIN USUALLY BETTER?

Morning	Afternoon	Evening
During sleep hours	Lying down flat	Standing
Walking	Sitting	Rest
Stress (mental) is less	Good posture	Exercise/Stretching

HAS YOUR PAIN BEEN ASSOCIATED WITH?

Excessive fatigue-malaise	Bowel or bladder disorders	Night pain or night time sweats
Weight loss	Ovarian pain	Abdominal pain
Low grade fever	Kidney pain/painful urination	Balance problems

