

NAME _____

DATE ____ / ____ / ____

Are you here because of an **AUTO ACCIDENT?** Y / N **WORK INJURY?** Y / N

Current Complaint

What is your problem(s)? _____

When did it begin? _____

The onset was () Sudden () Gradual

Has this occurred before? () Yes () No If so, when? _____

Have you tried any other treatments for this condition? () Yes () No Physical Therapy () Y () N
Results? _____

Have you previously been under chiropractic care () Yes () No
If yes, with whom? _____ Date of last visit? _____

Is your problem () Getting worse () Getting Better () Staying the same

Does anything help decrease your symptoms? _____

Check any of these activities that increase your pain:

- () Bending () Standing () Sitting () Lying down
() Lifting () Walking () Coughing () Straining with bowel
() Driving in car () Standing up from a chair movement

Lifestyle Restrictions

Are you more irritable due to this condition? () Yes () No

Have you missed any work due to this condition? () Yes () No How long? _____

Does the pain interfere with your sleep? () Yes () No

Are you unable to perform any of these activities:

- () Sports () Recreation () Hobbies
() Cleaning the House () Yardwork

Past Health History

Major surgeries () Yes () No Describe: _____

Previous auto accidents or Injuries () Yes () No Describe: _____

Have you ever been hospitalized? If So, Describe: _____

Have you been diagnosed as having any of these health problems:

() Yes () No High Blood Pressure? () Yes () No Diabetes?

() Yes () No Stroke, TIA, or Heart Disease? () Yes () No Cancer?

Are you a smoker? () Yes () No () Former smoker

Any other serious health problems not listed? _____

Are you currently taking any medications? Describe _____

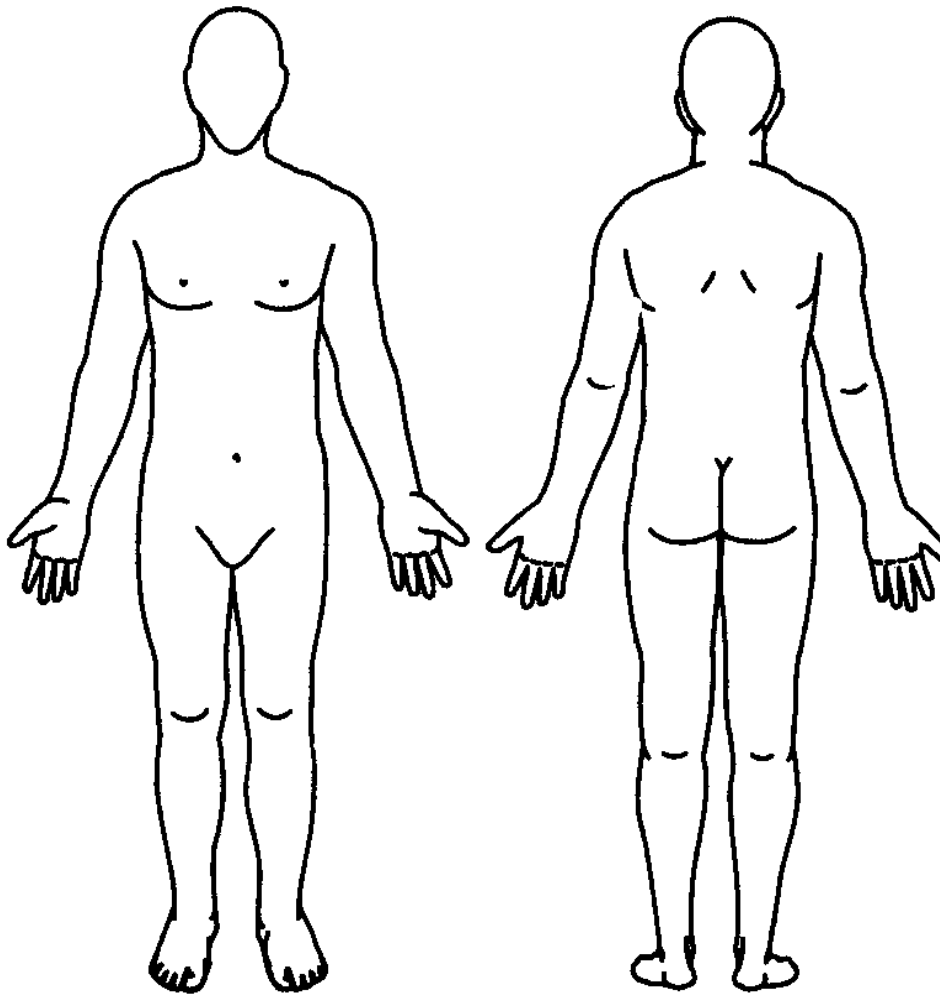
- () Pain killers () Muscle relaxants () Steroids
() Blood Pressure Medicine () Blood thinners

Please complete this drawing carefully.
 Mark on the drawing the areas where you feel the described sensation.
 Use the appropriate symbols and include all involved areas of your body.

NUMBNESS **===**
 BURNING PAIN **xxx**

PINS & NEEDLES **ooo**
 STABBING PAIN **|||**

ACHING PAIN **!!!**



| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

NO PAIN

EMERGENCY SITUATION

Using this scale, over the last 30 days the pain has been:
 at what level at its worst (0 to 10) _____
 at what level on average (0 to 10) _____

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