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Initial Symptom History

Please state your primary complaint of why you are here today:_____
_____

What caused this and how long have you had it:_____
_____

Have you had this condition in the past?_____

Please put a check that applies to your present condition:

Frequency: ____rare ____occasional ____frequent ____constant

Symptoms: ____ pain ____stiffness ____spasms

Intensity: 0 (none)- 10 (severe) = _____neck _____mid _____low back _____extremity

Quality: ____sharp ____dull ____stabbing

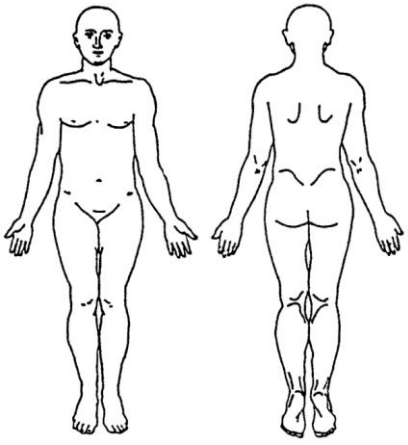
Assoc. Symptoms: ____weakness ____limited ranges of motion

radiating pain into_____ numb/tingling of_____

Aggravated by prolonged: ____sitting ____standing ____walking ____lying down ____driving

Relieved by: ____rest ____movement ____stretching ____Rx ____ice ____heat

Please mark the areas where your current complaints are located:



Signature_____**Date**_____

INITIAL HEALTH HISTORY

Allergies:_____

Medications/Supplements_____

Cholesterol Lowering Drugs:_____

Surgeries/Hospitalizations:_____

Pace Maker/Metal /Breast Implants_____

Cancer:_____
Diabetes:_____
Heart Disease:_____
Stomach/Colon:_____
Etc._____

Spinal Injuries/Accidents:_____

Previous Chiropractic Care: _____

Last Menstrual Period:_____ PREGNANT? ( ) YES ( ) NO

Previous MRI, CT Scans; X-Rays:_____
Sports Activities:_____times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ( )very high ( )high ( )medium ( )minimal

Patient Signature_____Date_____

Comments: