

PATIENT NAME:		DOB:	DATE:
	Complaint # 1	Complaint # 2	Complaint # 3
Complaint (low back, neck, hips, midback, headaches, sinus trouble, intestinal problems, dizziness, nausea)			
Location (up/low neck/back, betw shldr. blades, one/both sides)			
When did you first notice this?			
Has it happened before above date?			
Is it better/worse in a.m. or p.m.?			
Does the symptom travel to arms/legs/hands/feet?			
Does any position relieve symptom?			
Type of pain? (sharp, dull, achy, burn throb, numb, pins & needles)			
How many times a day/wk/mo/yr, or is it daily or constant?			
How long does it last? (min, hrs, days)			
Other doctors seen for this? (MD, Ortho, Chiro, Acup)			
What did they do? (Meds, Injections, Pain Ctr, P.T.)			
What have you tried? (ice, heat, rubs, massage, etc.)			
Medicines taken for this? Including over the counter?			
Does this affect/prevent daily activity?(y/n)			
Rate symptom on a scale 1-10 (10=worst) plus how it affects/bothers you			
Anyone recommend medicines? (y/n)			
Anyone recommend surgery? (y/n)			
List traumas (even minor) including car, work, falls, injuries, etc. (please include approx. date)			
Why do you think your body is not getting better on its own?			

Patient Signature _____ Date _____