

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

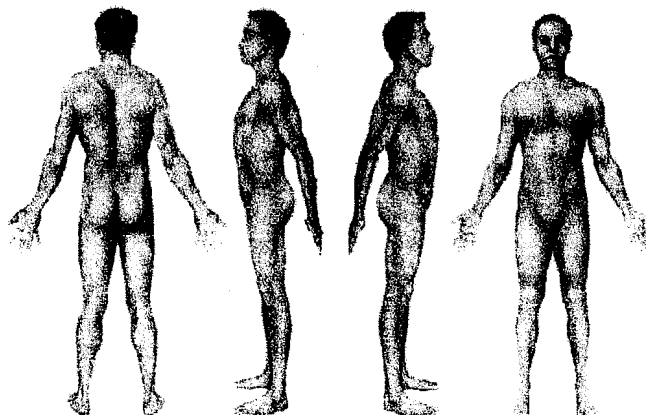
= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

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

What describes the nature of your symptoms?

- Sharp Dull ache Numb Shooting
 Burning Tingling Stabbing

How are your symptoms changing?

- Getting better Not changing Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- 0 None 1 2 3
 4 5 6 7
 8 9 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- Not at all A little bit Moderately Quite a bit
 Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time
 None of the time

In general, would you say your overall health right now is....

- Excellent Very good Good Fair
 Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist
 Other

Please use the chart below to inform us of any other medical conditions we should know about.

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

- Poor Circulation
- High Blood Pressure
- Aortic Aneurism
- Heart Disease
- Heart Attack
- Chest Pain
- High Cholesterol
- Pace Maker
- Jaw Pain
- Irregular Heartbeat
- Swelling of Legs

	No _____		
	Present	Past	No

Respiratory:

- Asthma
- Tuberculosis
- Shortness of Breath
- Emphysema
- Cold/Flu
- Cough/Wheezing

	No _____		
	Present	Past	No

Allergic/Immunologic:

- Hives
- Immune Disorder
- HIV/AIDS
- Allergy Shots
- Cortisone Use

	No _____		
	Present	Past	No

Genitourinary:

- Kidney Disease
- Lower Side Pain
- Burning Urination
- Frequent Urination
- Blood in Urine
- Kidney Stone
- Prostrate Problems

	No _____		
	Present	Past	No

Ears/Nose/Throat:

- Dizziness
- Hearing Loss
- Sinus Problems
- Nosebleed
- Sore Throat
- Difficulty Swallowing
- Bleeding Gums

	No _____		
	Present	Past	No

Gastrointestinal:

- Gallbladder Problems
- Bowel Problems
- Constipation
- Liver Problems
- Ulcers
- Diarrhea
- Nausea/Vomiting
- Bloody Stools
- Poor Appetite
- Loss of Bowel Control
- Loss of Bladder Control
- Heartburn/Indigestion

	No _____		
	Present	Past	No

Hematologic/Lymphatic:

- Hepatitis
- Blood Clots
- Cancer**
- Easy Bruising
- Easy Bleeding
- Fevers/Chills/Sweats
- **Location of Cancer _____

	No _____		
	Present	Past	No

Endocrine:

- Thyroid Disease
- Diabetes
- Hair Loss
- Menopausal
- Menstrual Problems

	No _____		
	Present	Past	No

Neurologic:

- Stroke
- Seizures
- Head Injury
- Brain Aneurysm
- Numbness
- Severe Headaches
- Pinched Nerves
- Parkinson's
- Carpal Tunnel
- Spinning/Balance
- Epilepsy
- Fainting

	No _____		
	Present	Past	No

Integumentary:

- Skin Ulcers
- Skin Disease
- Eczema
- Psoriasis
- Rashes

	No _____		
	Present	Past	No

Musculoskeletal:

- Gout
- Arthritis
- Joint Stiffness
- Muscle Weakness
- Osteoporosis
- Broken Bones
- Joints Replaced
- Rheumatoid Arthritis

	No _____		
	Present	Past	No

Psychiatric:

- Depression
- Anxiety Disorder
- Unusual Stress

	No _____		
	Present	Past	No

Constitutional:

- Weight Loss/Gain
- Energy Level Problem
- Difficulty Sleeping

	No _____		
	Present	Past	No

Permanent Disability Rating _____ %
 Other Conditions _____