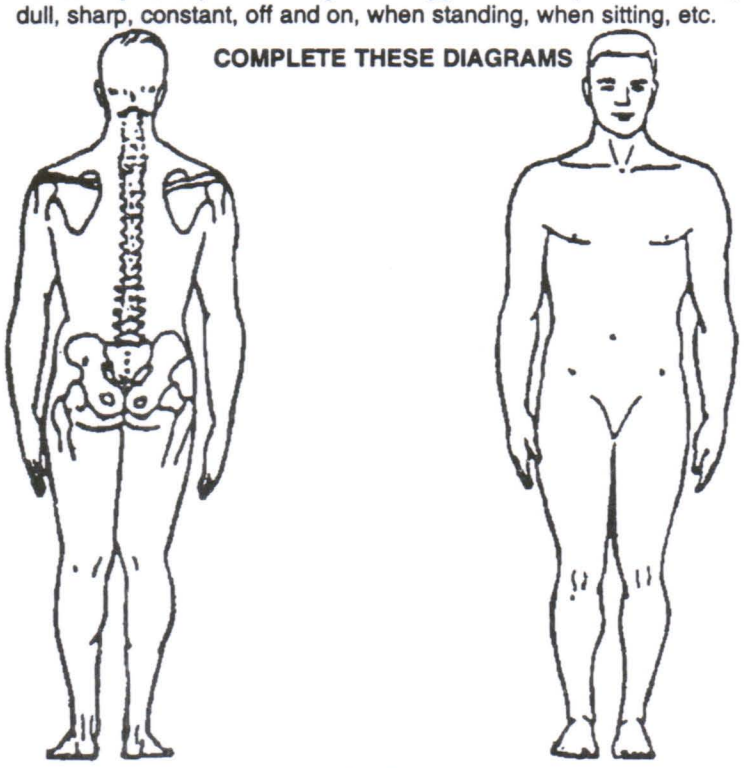
Name _____ Date _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off and on, when standing, when sitting, etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT
(Please describe only your major problem)

How did this condition develop? (What caused it? How did it start?) _____

When was the very first time you were aware of this problem? _____

Have you ever had this problem or a similar problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results? _____

Has this problem been getting better, worse, or staying the same? _____

Is there anything you do that makes your condition worse? _____

How has this condition affected your life?

A. Home life _____
B. Occupational life _____
C. Recreational life _____
D. Rest and Sleep life _____

Have you ever been in an automobile accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

What surgery has been done? _____

Are you pregnant? ☐ Yes ☐ No

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature _____ Social Security No. _____ Date _____