Please complete EVERY line, indicating N/A or NONE if appropriate **Chart #**_____

Have you ever been to a chiropractor before? ***YES or NO*** **If yes, date of last visit** _____

1st Complaint (*PRIMARY*):_____ **Since this issue began, it is now:** SAME BETTER WORSE
Does the pain travel (radiate) to any other parts of your body? ***YES*** **or** ***NO*** **If yes, to where?** _____
On a scale of 1-10 (*1- least severe, 10- most severe*) what is your level of discomfort?
1 2 3 4 5 6 7 8 9 10
Frequency of discomfort: continuous frequent occasional intermittent
Type of discomfort: Circle ***ALL*** that apply

aching	dull	sharp	stiffness	throbbing
burning	numbness	shooting	swelling	tingling

Other _____
Is this complaint worse at a certain time of the day? YES or NO If yes, when?_____
Circle: *Gradual or Sudden?* Date condition began: _____ **Cause**: _____
What makes it worse?_____**What makes it better?**_____
Have you been treated by another doctor for this condition? ***YES or NO***
If yes, name of doctor/healthcare facility? _____**What was treatment?**_____

2nd Complaint: _____ **Since this issue began, it is now:** SAME BETTER WORSE
Does the pain travel (radiate) to any other parts of your body? ***YES*** **or** ***NO*** **If yes, to where?** _____
On a scale of 1-10 (*1- least severe, 10- most severe*) what is your level of discomfort?
1 2 3 4 5 6 7 8 9 10
Frequency of discomfort: continuous frequent occasional intermittent
Type of discomfort: Circle ***ALL*** that apply

aching	dull	sharp	stiffness	throbbing
burning	numbness	shooting	swelling	tingling

Other _____
Is this complaint worse at a certain time of the day? YES or NO If yes, when?_____
Circle: *Gradual or Sudden?* Date condition began: _____ **Cause**: _____
What makes it worse?_____**What makes it better?**_____
Have you been treated by another doctor for this condition? ***YES or NO***
If yes, name of doctor/healthcare facility? _____**What was treatment?**_____

3rd Complaint: _____ **Since this issue began, it is now:** SAME BETTER WORSE
Does the pain travel (radiate) to any other parts of your body? ***YES*** **or** ***NO*** **If yes, to where?** _____
On a scale of 1-10 (*1- least severe, 10- most severe*) what is your level of discomfort?
1 2 3 4 5 6 7 8 9 10
Frequency of discomfort: continuous frequent occasional intermittent
Type of discomfort: Circle ***ALL*** that apply

aching	dull	sharp	stiffness	throbbing
burning	numbness	shooting	swelling	tingling

Other _____
Is this complaint worse at a certain time of the day? YES or NO If yes, when?_____
Circle: *Gradual or Sudden?* Date condition began: _____ **Cause**: _____
What makes it worse?_____**What makes it better?**_____
Have you been treated by another doctor for this condition? ***YES or NO***
If yes, name of doctor/healthcare facility? _____**What was treatment?**_____

Signature_____ **Date** _____
Intake