



**Symptoms**

1. What is your principal problem or the one area of greatest pain?  
\_\_\_\_\_

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is extremely severe pain.  
0 \_\_\_\_\_ 10

3. Do you think the pain has been getting worse? Yes / No  
If so, how quickly has it increased? Gradually / Suddenly

4. What do you think caused this problem?  
\_\_\_\_\_

5. How often do you experience this pain?  
 1-2 hrs per day     About half the day     Most of the day     The pain is constant

6. How does the pain affect your daily activities?  
 It does not affect them     I have had to change how I do things  
 I have had to stop doing some of them     I am unable to perform most daily activities

7. What increases your pain? \_\_\_\_\_

8. What decreases your pain? \_\_\_\_\_

9. Have you experienced this problem in the past? Yes / No    If so, when? \_\_\_\_\_

10. Which of the following treatments, if any, have you received for your complaint?  
 Medication     Physical Therapy     Massage  
 Chiropractic     Acupuncture     Other

11. Which of the above treatments have benefitted you the most?  
 Medication     Physical Therapy     Massage  
 Chiropractic     Acupuncture     Other

12. What do you expect from your visit to the clinic? \_\_\_\_\_

13. Do you have a pacemaker or any metal implants (e.g. screws)?  
If so, explain: \_\_\_\_\_

14. List any other issues currently bothering you and rate the pain level for each.  
a. \_\_\_\_\_ 0 \_\_\_\_\_ 10  
b. \_\_\_\_\_ 0 \_\_\_\_\_ 10

15. Have you ever been involved in an auto accident? Yes / No  
If Yes, when? \_\_\_\_\_  
Were you injured? Yes / No    If yes, complete the **Motor Vehicle Accident Form**

16. Have you ever been injured at work? Yes / No  
If Yes, when? \_\_\_\_\_    If yes, please complete the **Workplace Injury Form**

**Medical History / Other**

- 1. Please list all medications you are currently taking (including vitamins and over the counter medication) . \_\_\_\_\_
- 2. Please list all surgeries you have had with date(s). \_\_\_\_\_
- 3. Diet: Please rate your diet on the following scale : 0 = poor, 5 = healthy 0 \_\_\_\_\_ 5  
 Meals: \_\_\_ per day      Tobacco: \_\_\_ cigarettes per day      Alcohol: \_\_\_ drinks per week  
 Allergies / Other Dietary Concerns: \_\_\_\_\_
- 4. Exercise: \_\_\_\_\_ Cardiovascular: \_\_\_ x / week      Weights: \_ \_ x / week
- 5. If female, when was your last period? \_\_\_\_\_
- 6. If female, are you pregnant?      Yes / No / Unsure
- 7. Below are several lists of diseases and conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care. Please check all that apply.

Diseases

- |                                    |  |  |                                      |   |
|------------------------------------|--|--|--------------------------------------|---|
| <input type="checkbox"/> AIDS      | <input type="checkbox"/> Anaemia       | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis A B C D | <input type="checkbox"/> Influenza   | <input type="checkbox"/> Mental Disorder(s) |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Psoriasis     | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Smallpox    | <input type="checkbox"/> Stroke / ITA       |
| <input type="checkbox"/> Thyroid   | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Other       | _____                                       |

Cardiovascular & Pulmonary System

- |                                     |   |   |  |  |
|-------------------------------------|---|---|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Ankle/calf swelling | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Stroke     | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Lung problems  | <input type="checkbox"/> Congestion          | <input type="checkbox"/> Shortness of breath |

Gastrointestinal System

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Abnormal appetite | <input type="checkbox"/> Gas / bloating | <input type="checkbox"/> Upset stomach    | <input type="checkbox"/> Frequent nausea | <input type="checkbox"/> Colitis             |
| <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Hemorrhoids         |
| <input type="checkbox"/> Vomiting          | <input type="checkbox"/> Weight trouble | <input type="checkbox"/> Gall bladder     | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Dark / bloody stool |
| <input type="checkbox"/> Abdominal cramps  | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Irritable bowel  |  |  |

Genitourinary & Musculoskeletal Systems

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Bladder trouble      | <input type="checkbox"/> Vaginal pain       | <input type="checkbox"/> Breast pain/lumps | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Difficulty chewing |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Menstrual cramps   | <input type="checkbox"/> Vaginal infection | <input type="checkbox"/> Menstrual irreg'y  | <input type="checkbox"/> Low back pain      |
| <input type="checkbox"/> Clicking jaw         | <input type="checkbox"/> Neck pain          | <input type="checkbox"/> Discoloured urine | <input type="checkbox"/> Painful urination  | <input type="checkbox"/> Prostate problems  |
| <input type="checkbox"/> Walking difficulties | <input type="checkbox"/> Pain b/w shoulders | <input type="checkbox"/> Wrist / hand pain | <input type="checkbox"/> Arm pain           | <input type="checkbox"/> General stiffness  |

Nervous System / EENT

- |                                       |   |   |  |  |
|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Numbness             | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Paralysis       | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Confusion    | <input type="checkbox"/> Forgetfulness        | <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Tingling        | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Ears buzzing         | <input type="checkbox"/> Stress         | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Sore throat     |
| <input type="checkbox"/> Vertigo      | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Grinding teeth |  |  |

**Authorization**

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_