Alliance Chiropractic Center

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Name: ____

Symptoms: ____

Severity: no pain– 0 1 2 3 4 5 6 7 8 9 10 –worst pain imaginable

Frequency (% of the day present) ________________________________

Character (how it feels) _______________________________________

When did your symptoms begin: _________________________________

How did your symptoms begin: __________________________________

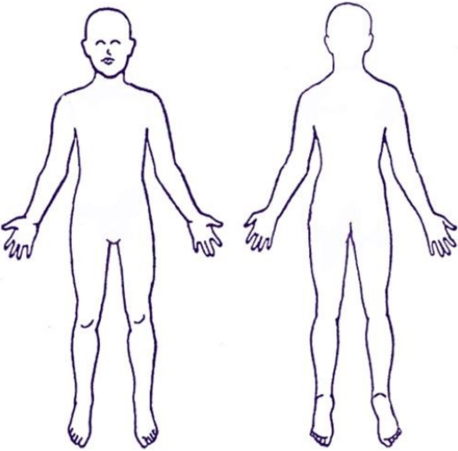
____

Have you had it before? When? _________________________________

____

Additional symptoms: ____

____



Please mark on the diagram where you have pain

____

Does your pain radiate? Where?____

Is your condition improving, getting worse or not changing? ______________________________________

What makes you feel BETTER (even a little)? ____

What makes your pain WORSE? ____

What treatments have you tried? Result? ____

Who else have you seen for this problem? ____

What are you having trouble doing? ____

What can you NOT do at all because of pain? ____

Have you missed work or school? How many days? ____

Anything else we should know regarding this issue or your health? _________________________________

____

Signature: ____ Date: _______________________