Complaint Form

Date: ___/___/___

Name: _____ Sex: M F Age: _____

List and date **ANY** surgeries: _____

List and date **ANY** accidents or serious injuries (broken bones or dislocations):

_____

List and date **ANY** diagnosed diseases: _____

Family Physician: _____ Phone #: _____

Date of last physical exam: _____ By whom: _____

Have you ever had (circle all that apply): Spinal X-Rays MRI CAT Scan

CURRENT COMPLAINTS/SYMPTOMS:

When did you first notice the problem? _____

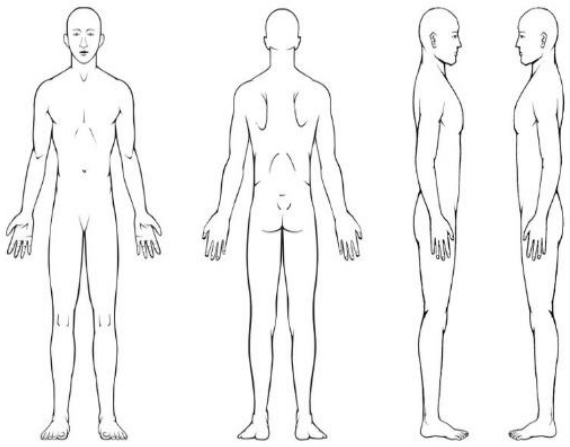
What do you think caused the problem? _____

Describe the problem (Be as specific as possible): _____

_____

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

Numbness	**xxxxxxxxx**	**The Problem:**	
Pins & Needles	**……**	**Comes and goes**	**Is Constant**
Burning	**ooooooooo**		
Aching	**vvvvvvvvv**	**The problem came on:**	
Stabbing	**lllllllllllllll**	**Gradually**	**Suddenly**



PAIN LEVEL: On a scale of 1-10, with 0 being you're pain free and can function quite well, and 10 being you're in very severe pain and cannot function at all, where would you rate yourself? (Place an X on the line.)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN **VERY SEVERE PAIN**

What activities, positions, or movements make the problem **worse**?

_____

What activities, positions, or movements make the problem **better**?

_____

Have you ever had this problem before: Yes_____ No_____ if Yes, when?_____

Have you ever had chiropractic care before? Yes____ No____ If yes, from whom?_____

For what problems: _____ For how long? _____

Are you currently taking any medications (Include regularly used over the counter medications)

Medication Name	Dosage and Frequency (ie. 5 mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Family Medical History (Record one diagnosis in your family history and the affected)

Diagnosis	Father Alive: Y__ N__	Mother Alive: Y__ N__	Sibling: How many: ____	Offspring: How many: ____
Example: heart disease				

Indicate Habits: Smoking, _____pks/day Alcohol, _____drinks/day Coffee, _____cups/day

<u>CIRCLE</u> ALL THE SYMPTOMS YOU CURRENTLY HAVE AND <u>UNDERLINE</u> ANY YOU HAVE HAD

GENERAL SYMPTOMS	GASTRO-INTESTINAL	CARDIOVASCULAR	EYE/EAR/NOSE/THROAT
Headaches	Poor appetite	Rapid heart rate	Poor Vision
Fevers	Excessive hunger	Slow heart rate	Crossed eyes
Chills	Belching or gas	High blood pressure	Poor hearing
Night sweats	Nausea	Low blood pressure	Earache / Infection
Fainting	Vomiting	Pain over heart	Ringing in ears
Dizziness	Pain over stomach	Heart trouble	Nose bleeds
Convulsions	Constipation	Swelling of ankles	Sore throat / hoarseness
Fatigue	Diarrhea	Poor circulation	Asthma
Nervousness	Hemorrhoids		
Loss of Weight			
Allergies	**SKIN**	**RESPIRATION**	**GENITO-URINARY**
Hernia	Itching	Chronic cough	Frequent / painful urination
Weakness	Bruise easily	Spitting blood	Blood in urine
Twitching	Eczema	Chest pain	Inability to control urination
Swollen joints		Difficulty breathing	Prostate trouble
Tremors			Male / Female reproduction

Please list **ANY** other health problems or symptoms not covered: _____

_____