

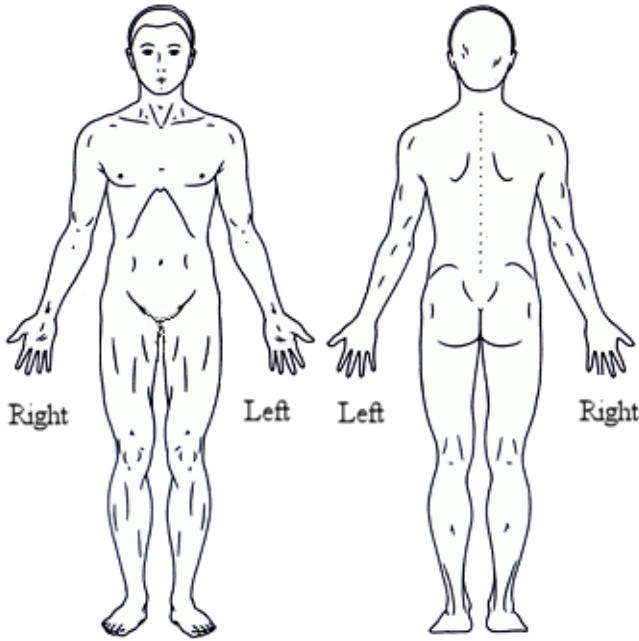
Symptoms and Present State of Health

Patient: \_\_\_\_\_

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

Present Complaint/Reason for Seeking Care in this Office: \_\_\_\_\_

This episode of pain or problem started on \_\_\_\_\_ Previous Episodes \_\_\_\_\_



Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =

Burning XXX

Dull Ache OOO

Sharp/Stabbing / / /

Pins, Needles + + +

Other \_\_\_\_\_ ^ ^ ^

Describe: \_\_\_\_\_

How many days per month does is presenting complaint occur? \_\_\_\_\_

Frequency during day:  Constant (76-100% of time)  Frequent (51-75%)  Occasional (26-50%)  Intermittent(1-25%)

Only with specific activities. Please explain: \_\_\_\_\_

Does this pain shoot, radiate, or travel in your body? YES / NO Where? \_\_\_\_\_

Since problem began, is it:  Same  Better  Worse

Please Circle:

Current level of discomfort: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

When problem is at its worst: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Average level of discomfort: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

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Is this condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with: Work: \_\_\_ Sleep: \_\_\_ Routine: \_\_\_ Other? \_\_\_\_\_

Explain: \_\_\_\_\_

Have you been treated for same or similar problems in the past? YES / NO

Who treated you? \_\_\_\_\_

What was the treatment you received? \_\_\_\_\_

What was outcome? \_\_\_\_\_

Did you have any imaging or testing performed? \_\_\_\_\_

Are you under medical care for any condition? \_\_\_\_\_

What Medications are you taking? \_\_\_\_\_

Have you had surgery? YES / NO What / When? \_\_\_\_\_

What side effects have you experienced from the drugs and surgery? \_\_\_\_\_

Females Only – Date last Menstrual Period began on \_\_\_\_\_ Are you possibly Pregnant? \_\_\_\_\_

Please mark any of the following conditions or symptoms that you have now or have experienced:

**Other Symptoms:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pain in Hands or Arms     | <input type="checkbox"/> Chest Pains            |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack           |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Pain in Legs or Feet      | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Numbness in Legs or Feet  | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Depression                | <input type="checkbox"/> Painful Urination      |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Lights Bother Eyes        | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Loss of Memory            | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Shoulder Pain             | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Sinus                     | <input type="checkbox"/> Stomach Upset          |
| <input type="checkbox"/> Joint Swelling         | <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Heartburn/Reflux       |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Weight Loss            |
| <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Cold Hands                | <input type="checkbox"/> Menstrual Cramps       |
| <input type="checkbox"/> Jaw/TMJ Problems       | <input type="checkbox"/> Cold Feet                 | <input type="checkbox"/> Menopause              |

**Is there a family History of:**

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient  
Signature \_\_\_\_\_ Date \_\_\_\_\_