

## Health History

Have you ever had Chiropractic care before?  Yes  No

What treatment have you already had for your condition?

Medication  Chiropractic Care  Surgery  Physical Therapy  None Other \_\_\_\_\_

Name of other doctors who have treated you for this condition: \_\_\_\_\_

List any surgical operations you have had. : \_\_\_\_\_

List all unusual diseases / illnesses you may suffer from. : \_\_\_\_\_

Exercise:  None  Moderate  Daily  Heavy

Work Activity:  Sitting  Standing  Light Labor  Heavy Labor

## Patient Condition

Reason for Visit : \_\_\_\_\_

When did your symptoms appear? : \_\_\_\_\_

Is your condition getting progressively worse?  Yes  No  Unknown

Is your condition interfering with your :  Work  Sleep  Daily Routine  Recreation

Rate the severity of your pain : | ..... |  
0 5 10  
No Pain Worst Pain

Mark an X on the picture in the places where you have pain, numbness, or tingling.

