Patient Name: _____

Reason for Visit: _____

When (date) did your symptoms appear? _____

Is this condition (circle one): getting worse getting better staying the same

Rate your pain with one number that describes your pain in the last week: **The best:**_____
The worst:_____
Now: _____

☺ **No Pain 1 2 3 4 5 6 7 8 9 10 Horrible Pain** ☹

Type of pain (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps

Stiffness Swelling Other: _____

How often do you have these symptoms (circle one)? Constant Comes and goes

Your pain interferes with your (circle): Work Sleep Daily Routine Recreational Activities

Activities or movements that are painful to perform (circle): Sitting Standing Walking Bending Lying Down Reaching

What treatment have you already received for this condition (circle all that apply):

Medications Surgery Physical Therapy Chiropractic None Other: _____

Have you had 2 or more falls within the last 12 months? Yes No (If more than 2 falls, speak to your doctor about taking Vitamin D)

Have you had an injury resulting from a fall? Yes No

Exercise Level (circle): None Moderate Daily Heavy

Habits (circle): Smoking Alcohol Coffee/Caffeine High Stress Level

Are you pregnant? Yes No Due Date: _____

At the present time, would you say your health is: excellent, very good, fair, poor?

Please list any past surgeries, broken bones, dislocations, other injuries: (please include date)

_____ _____

_____ _____

_____ _____

Please indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Anemia			Hernia			Polio		
Arthritis			Herniated Disk			Prosthesis		
Asthma			High Cholesterol			Rheumatoid Arthritis		
Cancer			Migraines			Scarlet Fever		
Diabetes			Multiple Sclerosis			Stroke		
Epilepsy			Osteoporosis			Tumors		
Goiter			Pacemaker			Other:		
Gout			Parkinson's					
Heart Disease			Pinched Nerve					