Symptom Information:

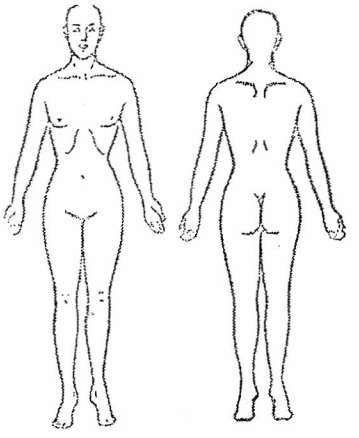
1.Please describe the health problem for which you came to our office._____

_____

2.Describe the character of your symptoms. Some words often used are burning, tingling, tired, numb, sharp pain, dull ache, stabbing, shooting, radiating etc. _____

_____

3.Shade in the areas on the diagram where you feel discomfort or symptoms.



4.Please put a mark on the scale to show how bad your usual discomfort has been recently. If you are describing more than one symptom indicate the pain for each one.

No Discomfort	1	2	3	4	5	6	7	8	9	10	Worst discomfort possible

5. How long have you had this episode of symptoms?_____

6. How many times have you had a problem similar to or the same as this one in the past?
None previously_____ 1-5 episodes_____ 6-10 episodes_____

7.When was the first time you felt something similar to or the same as your current problem?
Less than 6 months____ 6months to 1 year_____ 1-5 years____5-20 years_____

8. Did symptoms begin gradually over time or suddenly?_____

9. Since your symptoms began, have they ___improved ___ worsened ___stayed the same?

10. Are your symptoms constant?_____ If there are any times or positions when you do not experience your pain/ discomfort please explain (example- after exercising, while sleeping).

_____

11. What caused your symptoms to occur? BE SPECIFIC (lifting, fall, accident, stress)

_____

12. What aggrevates your current symptoms?_____

_____

13. Is your sleep disturbed by this problem?_____

14. Do you sleep on a ____mattress and box spring, ____ water bed ___ futon ____ other_____
What is your predominant sleeping position?____back ___side___ stomach___other

15.If you are restricted/limited in any work, home, or recreational activities because of your discomfort please describe how?_____

_____

16. Have you missed any work because of this problem and if so when?_____

17.Are your symptoms the result of an auto accident, work injury or other personal injury____
If you answered yes, please fill out an accident specific form, available at front desk.

18. Do you participate in any regular type of exercise?_____ If yes, what type and how often?_____

19.Have you seen a Chiropractor in the past for this or any other spinal problem?_____
If yes, whom did you see and when?_____
Were x-rays taken?_____What type of treatment did you receive?_____

_____

How much did it help? 1----------10 full improvement

20. Have you seen an M.D., D.O. or any other type doctor for this problem?_____

21. Are you aware of any other blood relatives with similar discomforts/ problems?_____

22. Do you have any condition or disease or problem not previously mentioned?___yes ___no
If yes, please describe_____

_____

23. Do you smoke or use any tobacco products?_____If yes, how often?_____
24. Do you drink alcoholic beverages?_____If yes, how often?_____
25. Have you had any serious illnesses/ trauma's or SURGERIES?_____ If yes, please list and describe._____

_____

_____

Women Only:

a. Are you pregnant or think you may be pregnant?_____
b. Date of last menstrual period_____
c. Do you suffer from menstrual disorders?_____
If yes, please describe_____