Subjective Complaint

1. Home Address

Address 1

Address 2

City

State

Zip Code

2. Contact Information

Mobile Phone

Home Phone

Primary Email Address

3. Demographic Information

Sex at birth:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

4. Personal Information

Height - Feet:

Height - Inches:

Weight (in pounds):

5. Emergency Contact Information

Emergency Contact Name:

Contact Phone Number:

Relationship to Patient:

6. Employer Information

Employment Status:
○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name:

Occupation:

Physical Work Duties:

7. Referral Information

Referring Physician:

Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

_____

8. What is your current pain rating, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain?

○ 0 (no pain) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (severe pain)

Subjective Complaint

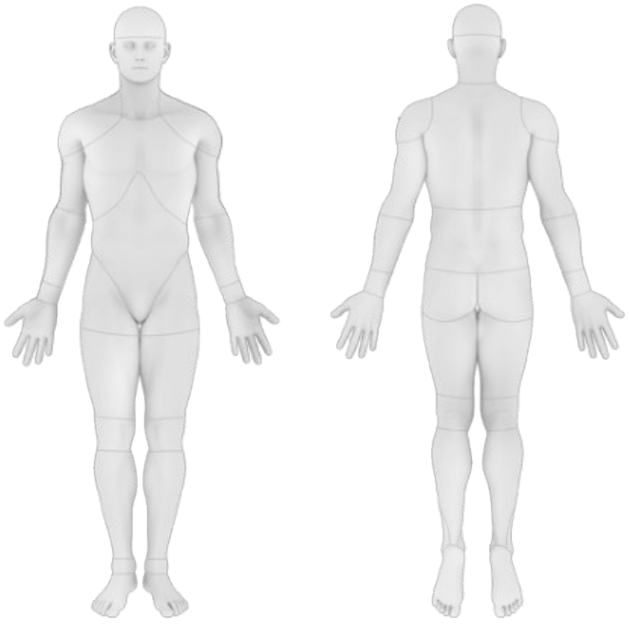
9. What are you coming in for today?

- ○ Continued care of an ongoing concern
- ○ New concern
- ○ Maintenance or Wellness Visit

10. Is there anything else you want to make your provider aware of today?

Primary area of concern

11. Which body region is responsible for your primary complaint



12. date of onset

Approximate date this condition began (exact date not required)

What caused this condition?

What is your additional area of concern?

13. Does the discomfort radiate/travel?

- Yes
- No

14. Where does the discomfort radiate/travel to?

15. Please rate your pain/discomfort

Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

16. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other,specify:

17. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Nothing		
Other		

If other, specify:

18. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

_____

19. Have you ever had any previous episodes of this condition?

- ○ Yes
- ○ No

If Yes, specify:

_____

20. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
None		
Other		

If other, specify:

_____

21. Has your overall condition gotten better, same or worse?

- ○ Improved
- ○ Worsened
- ○ Stayed the same
- ○ Relief which lasted for awhile

22. Have other health care provider(s) performed tests related to this condition?

- ○ Yes
- ○ No

If Yes, specify:

_____

23. Please list the specific activities or movements that are affected by this concern (for example, bending over, getting in/out of car, using a computer, etc.)

24. Has the activity shown signs of improvement or worsening? (check all that apply)

- ☐ Improved because of less pain
- ☐ Improved because of less stiffness
- ☐ Improved because of greater range of motion
- ☐ Stayed the same
- ☐ Worsened because of more pain
- ☐ Worsened because of more stiffness
- ☐ Worsened because of less range of motion

25. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

_____

26. Do you have an additional complaint?

- ○ Yes
- ○ No

27. CURRENT HEALTH

28. Are you currently taking any medications?

- ○ Yes
- ○ No

29. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		

30. Other than the condition(s) already shared, do you have any additional health concerns?

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular Condition		
Skin or Bleeding Conditions		
Do you have any medication allergies?		

31. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

PERSONAL AND FAMILY HISTORY

32. Health history

	Yes	No
Have you had any surgical procedures?		
Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?		

33. Details of health history

If you have answered yes to any of the above, please share this info with your doctor.

WORK, SOCIAL, HABITS

34. Current work status

Current work habits - Choose all that apply.

☐ Permanently fully disabled ☐ Permanently partially disabled ☐ Cannot work due to current condition
☐ Full-time (20-40+ hours/week) ☐ Part-time (1-19 hours/week) ☐ Retired ☐ Student ☐ Homemaker
☐ Unemployed

35. Personal social habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

36. Present exercise habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

37. Diet and nutrition habits

	Yes	No
Vegan or vegetarian		
Daily supplements		
Other		

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Print name (s) doctor (s) treating this patient: