



REASON FOR VISIT

Name: _____ Date: _____

Occupation: _____ Ht: _____ Wt: _____ Age: _____

1. Reason for visit: _____

2. How long have you had this problem? _____

3. Did you have an injury? **Yes** **No** Date of Injury _____

4. Was the onset **sudden or gradual?** (Please circle) **Sudden** **Gradual**

5. If you have pain, where is it located? _____

6. Describe the pain (Please circle) Dull Sharp Aching Throbbing Electric
Burning Other: _____

7. Do you have any of the following symptoms? (Please circle)

Warmth Redness Bruising Swelling Clicking Locking
Popping Giving way Weakness Stiffness Joint looseness
Dislocation Numbness/tingling

8. How bad is the pain on a scale of 0-10? 0= no pain, 10=worst imaginable pain _____

9. Do you have pain at night? Circle **Yes** **No** Does the pain wake you up from sleep? **Y** **N**

10. What relieves your pain? _____

11. What makes your pain worse? _____

12. What does your problem limit you from doing? _____

13. Is your problem getting **better** getting **worse** or staying the **same** ?

14. Have you had physical therapy? **Yes** **No** Did it help? **Yes** **No**

15. Have you seen a chiropractor for this? **Yes** **No** Did it help? **Yes** **No**

16. Have you had massage for this? **Yes** **No** Did it help? **Yes** **No**

17. Have you had acupuncture for this? **Yes** **No** Did it help? **Yes** **No**

18. Have you done any other complementary/alternative treatments for this problem?

Yes **No** Did it help? **Yes** **No**

Please list: _____

19. Have you had an injection(s)? **Yes** **No** Did it help? **Yes** **No**

20. Were you prescribed medicine? **Yes** **No** Did it help? **Yes** **No**

21. What is the name of the medicine(s) you were prescribed? _____

22. Are you taking or doing anything else to help with your symptoms? _____
