PLEASE CIRCLE ALL THAT APPLY:

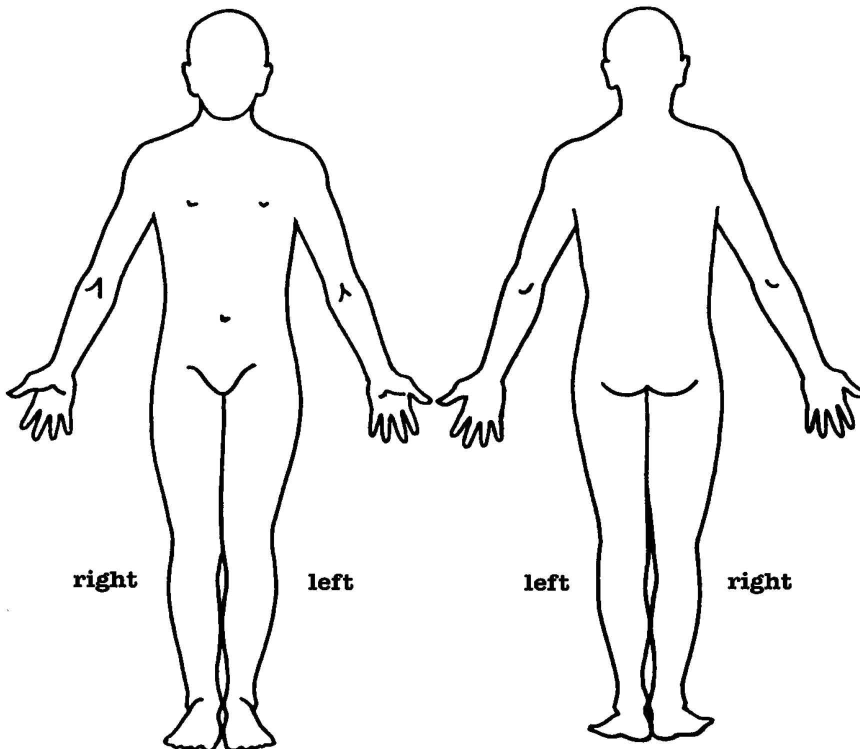
1. My problem is getting BETTER WORSE SAME.
2. My pain is SHARP DULL STABBING THROBBING SHOOTING TOOTHACHE
3. I have tried ICE HEAT and it has HELPED GOTTEN WORSE STAYED THE SAME
4. Along with my major complaint, I also periodically have : HEADACHES NECK PAIN MID BACK PAIN LOW BACK PAIN NUMBNESS OR TINGLING IN THE ARMS OR LEGS

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Pain Chart



PLEASE INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES USING THESE CODES:
U= UNABLE P= PAINFUL
D= DIFFICULT L= LIMITED

____ COUGHING OR SNEEZING
____CLIMBING
____ GETTING IN OR OUT OF A CHAIR
____ KNEELING
____ BENDING FORWARD
____ BALANCING
_____TURNING OVER IN BED
_____DRESSING
____ WALKING SHORT DISTANCE
____SLEEPING
____ STANDING MORE THAN 1 HOUR
____ STOOPING
____ SITTING AT A TABLE
____ GRIPPING
____ LYING ON BACK
____ PUSHING
____ LYING FLAT ON STOMACH
____ PULLING
____ LYING ON SIDE
____ REACHING
____ BENDING OVER FORWARD
____SEXUAL ACTIVITY

Do you have or have you had cancer? ___ Yes ___ No Treatment____
Do you have or have you had:
Heart disease ____ Yes ____ No Diabetes ____ Yes ____ No High blood pressure ____ Yes ____ No

IF FEMALE, IN SIGNING THIS FORM, I STATE THAT TO THE BEST OF MY KNOWLEDGE, THERE IS NO PREGNANCY, CONFIRMED OR SUSPECTED AT THIS TIME. All information from your file is held in strictest confidence. Nothing you report to us is revealed to anyone not authorized by you to have this information.

I hereby give my permission for Chirolina Chiropractic to:

1. Release medical information to my insurance company and/or attorney, as well as any physician this clinic may send me to for further evaluation.
2. Administer care and perform clinical procedures.
3. Collect in a current and timely manner acceptable to the clinic any and all fees for services. If I have been involved in a work-related injury and my claim is denied, I accept full responsibility for services rendered.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN:____________________________DATE:___________
WITNESS:____________________________________