INNOVATIVE PAIN AND WELLNESS™
Future. Personal. Hope.

Chiropractic Clinical Information

Today's Date: _____

Your Name: _____

Date of Birth: _____Height: _____ Weight: _____

Where is your worst area of pain located?

_____

_____

Please list any additional areas of pain: _____

_____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode?

- ☐ Diving accident
- ☐ Fall from height
- ☐ High energy
- ☐ Low energy
- ☐ Moderate energy
- ☐ Motor vehicle accident
- ☐ Twisting
- ☐ Flexion/extension
- ☐ Heavy lifting
- ☐ Unknown

Pain Description- Check all the following that describe your pain

- ☐ Aching
- ☐ Acute
- ☐ Chronic
- ☐ Constant
- ☐ Dull
- ☐ Improving
- ☐ Intermittent
- ☐ Pressure
- ☐ Sharp
- ☐ Squeezing
- ☐ Stabbing
- ☐ Stable tension
- ☐ Throbbing
- ☐ Worsening

Pain Frequency

What word best describes the frequency of your pain? (Circle One) **Daily** or **Intermittent**

Does the pain radiate? (Circle one) **Yes** or **No**

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Factors that affect your pain

- ☐ Sitting
- ☐ Rest
- ☐ Activity
- ☐ Eating
- ☐ Standing
- ☐ Position change
- ☐ Medication
- ☐ Heat
- ☐ Exertion
- ☐ Ice
- ☐ Physical therapy
- ☐ stress

Factors that reduce your pain

- ☐ Manipulation
- ☐ Walking
- ☐ Heat
- ☐ Ice
- ☐ Exertion
- ☐ Rest
- ☐ Activity
- ☐ Position change
- ☐ Medication
- ☐ Cold compress
- ☐ Physical therapy
- ☐ Stretching

Current Pain Level

_____ What number on the pain scale (0-10) best describes your pain **right now**?

_____ What number on the pain scale (0-10) best describes your **worst pain**?

Timing of Episodes

When does your current episode of pain begin?

- ☐ Upon awakening
- ☐ In the morning
- ☐ In the afternoon
- ☐ In the evening
- ☐ At night
- ☐ During sleep

What is the frequency of your current pain episode?

- ☐ Hourly
- ☐ Monthly
- ☐ Yearly
- ☐ Increasing
- ☐ Decreasing
- ☐ Unchanged
- ☐ Daily
- ☐ weekly

Past Surgical History

- ☐ I have not had any surgical procedures.
- ☐ I have had surgical procedures. (Please list)

_____

_____

Diagnostic Imaging

- ☐ I have not had any diagnostic imaging for current pain complaints.
- ☐ I have had diagnostic imaging done.
  - MRI
  - Xray
  - CT Scan
  - Ultrasound
  - EMG

Current Medications (Please list)

- ☐ No current Medications

_____

_____

Family Medical History

- ☐ No pertinent family medical history.

Mother:

_____

Father:

_____

Food Allergies

- ☐ No food allergies.
- ☐ I have the following food allergies:

_____

Social History

Are you pregnant? Yes or No

Have you had any broken bones? Yes or No

If so, please list:_____

_____

Highest level of education obtained:

- ☐ Grade school
- ☐ High school
- ☐ College
- ☐ Post-Graduate

Alcohol Use:

- ☐ Current Alcoholism
- ☐ Daily Limited Alcohol Use
- ☐ History of Alcoholism
- ☐ Never Drinks Alcohol
- ☐ Social Alcohol Use

Tobacco Use:

- ☐ Current Tobacco Use
- ☐ Former Tobacco User
- ☐ Never Tobacco User

Drug Use:

- ☐ Denies Any Illegal Drug Use
- ☐ Currently Using Illegal Drugs (Which ones)

  _____
- ☐ Formerly Used Illegal Drugs (Which ones)

  _____