Date: ____________________

Inspire Chiropractic & Wellness

CHIROPRACTIC

Name and Account #: **Birth Date:**

What is your: **Height** __________ **Weight:** ________

1. **PRIMARY CHIEF COMPLAINT:** ____

____

Additional Complaints: ____

____

2. **Complaint Began when and how:** ____

____

3. **Circle all that apply to the Quality of the complaint:**

Dull Aching Sharp Shooting Burning Throbbing Deep Other ______________________

4. Is this ☐ **AUTO Related** / ☐ **WORK Related** **OR** ☐ **Neither**

5. List all Healthcare providers in the LAST YEAR you have seen for this complaint:

____

____

6. Circle the Severity of the complaint:

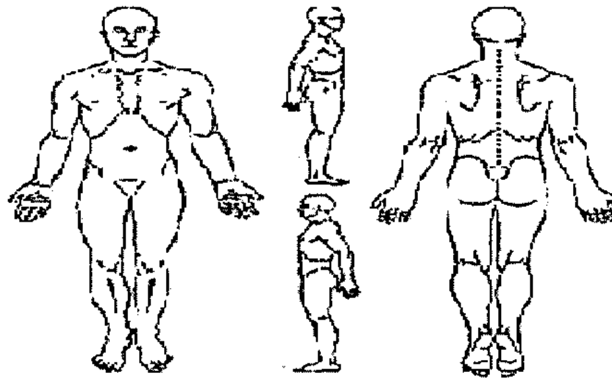
(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 **(Worst possible pain/complaint)**

<MILD> <MODERATE> <SEVERE>

7. In the past week, how much has your pain interfered with your daily activities? (e.g. work)

(No interference) 10 9 8 7 6 5 4 3 2 1 0 **(Unable to carry on any activities)**

8. **PLEASE TRACE YOUR AREA OF COMPLAINT BELOW:**



9. **COMPLAINT CHARACTERISTICS**

A. Does this complaint **radiate or travel (shoot)** to any areas of your body? YES NO Where: ______________________

____

B. Do you have any **numbness or tingling** in your body? YES NO Where: ______________________

____

C. How **frequent** is complaint present, how long does it last? ______________________

____

D. Is it **worse** in the morning, afternoon, evening, or at rest? ______________________

____

E. Does anything **aggravate** the complaint? ______________________

____

F. Does anything **relieve** the complaint? ______________________

____

Date: ______________