PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: *(Please rate your symptoms 1-10, with 1 being the least serious)*

Rating

1 ....
2 ....
3 ....
4 ....
5 ....
6 ....
7 ....
8 ....

Symptoms are worse in ☐ Morning ☐ Afternoon ☐ Night

When and how occured? ....
....

Symptoms developed from: ☐ Job related injury ☐ Autoaccident ☐ Other

☐ Accident ☐ Illness ☐ Unknown cause ☐ Gradual onset Date occurred: ....

Symptoms have persisted for # .... Hour(s) .... Day(s) .... Week(s) .... Month(s) .... Year(s)

Symptoms/Complaints: ☐ Come & go ☐ Are constant

Have you ever had this before: ☐ No ☐ Yes When? ....

If you were to guess, what do you think is causing your complaints? ....
....

Name and location of doctors previously seen for present conditions(s) ....
....

Are you allergic to any medications: ☐ No ☐ Yes What kind? ....

Are you taking any medications: ☐ No ☐ Yes What kind? ....

Are you pregnant ☐ No ☐ Yes Date of last period ....

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:

☐ Bending ☐ Reaching ☐ Straining at stool ☐ Coughing ☐ Sitting ☐ Turning head
☐ Lifting ☐ Sneezing ☐ Walking ☐ Lying down ☐ Standing

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

☐ Bending ☐ Sitting ☐ Lifting ☐ Standing ☐ Lying down ☐ Turning head ☐ Reaching
☐ Walking

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

☐ Blurred vision ☐ Buzzing in ears ☐ Cold feet ☐ Cold hands ☐ Cold sweats ☐ Concentration loss/Confusion
☐ Constipation ☐ Depression/Weeping spells ☐ Diarrhea ☐ Dizziness ☐ Face flushed ☐ Fainting
☐ Fatigue ☐ Fever ☐ Head seems too heavy ☐ Headaches ☐ Insomnia ☐ Light bothers eyes ☐ Loss of balance
☐ Loss of smell ☐ Loss of taste ☐ ☐ Low resistance to colds ☐ Muscle jerking ☐ Numbness in fingers
☐ Pins and needles in arms ☐ Stiff neck ☐ Pins and needles in legs ☐ Ringing in ears ☐ Shortness of breath
☐ Stomach upset

Patient Signature: .... Date: ....