

Patient Form

Patient Information:

Full Name: _____ Age: _____ ☐ Female ☐ Male
Date of birth: _____ Phone: _____
Address: _____ City: _____ ZIP Code: _____
Email Address: _____
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text
Emergency Contact Name: _____
Relationship: _____ Phone: _____

What body area(s) are you seeking evaluation for? (check all that apply)

- ☐ Neck ☐ Shoulder (L / R) ☐ Hip (L / R) ☐ Headache
☐ Mid Back ☐ Elbow (L / R) ☐ Knee (L / R) ☐ Chest / Ribs
☐ Low Back ☐ Wrist / Hand (L / R) ☐ Ankle / Foot (L / R) ☐ Abdomen
☐ Other: _____

When did your symptoms begin?

- ☐ Today ☐ Past week ☐ Past month ☐ 1-3 months
☐ 3-6 months ☐ > 1 year ☐ Unsure ☐ Other: _____

How would you rate the intensity of your symptoms?

- ☐ minimal ☐ mild ☐ mild to moderate
☐ moderate ☐ moderate to severe ☐ severe

What is the frequency of your symptoms?

- ☐ Rare ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

How are your symptoms progressing?

- ☐ Changes Daily ☐ Improving ☐ Not improving ☐ Worsening

Describe the symptoms you're experiencing: (please select all that apply)

- ☐ Achy ☐ Burning ☐ Numbness/Tingling ☐ Muscle Spasm
☐ Sharp ☐ Throbbing ☐ Stiffness ☐ Trouble Sleeping
☐ Dull ☐ Radiating ☐ Weakness ☐ Other: _____

What self-care treatment have you tried to help symptoms? (please select all that apply)

- | | | | |
|-------------------------------|-------------------------------------|---|---------------------------------------|
| ☐ Rest | ☐ Stretching | ☐ OTC Medication | |
| ☐ Ice | ☐ Exercise | ☐ TENS | ☐ Other: _____ |
| ☐ Heat | ☐ Massage | ☐ None | |

What physical limitations do you have?

- | | | |
|---|---|---|
| ☐ no limitations | ☐ mild to moderate limitations | ☐ severe limitations |
| ☐ mild limitations | ☐ moderate limitations | ☐ completely limited |

What is your current work status? (select all that apply)

- | | | |
|---|--|---------------------------------------|
| ☐ Working without restrictions | ☐ Missed work due to symptoms | ☐ Not employed |
| ☐ Working with restrictions | ☐ Currently off work | |

Cardiovascular (CHECK ONLY IF YES)

- | | | | |
|-------------------------------------|--|------------------------------------|--|
| ☐ Chest Pain | ☐ Shortness of breath | ☐ Dizziness | ☐ Irregular Heartbeat |
|-------------------------------------|--|------------------------------------|--|

Respiratory (CHECK ONLY IF YES)

- | | |
|--|--|
| ☐ Chest tightness | ☐ Chronic cough |
|--|--|

Neurologic (CHECK ONLY IF YES)

- | | | |
|---|--|--|
| ☐ Balance Problems | ☐ Weakness | ☐ Numbness/tingling |
| ☐ Memory Issues | ☐ Speech Difficulty | |

Musculoskeletal (CHECK ONLY IF YES)

- | | | |
|--|------------------------------------|---|
| ☐ Back Pain | ☐ Neck Pain | ☐ Joint pain/stiffness |
| ☐ Muscle aches/spasms | ☐ Leg Pain | ☐ Sciatica |

General (CHECK ONLY IF YES)

- | | | | |
|----------------------------------|--------------------------------|-----------------------------------|--|
| ☐ Fatigue | ☐ Fever | ☐ Headache | ☐ Sleep disturbance |
|----------------------------------|--------------------------------|-----------------------------------|--|

ENT / Eyes (CHECK ONLY IF YES)

- | | | |
|---|--|---|
| ☐ Vision changes | ☐ Ringing in ears | ☐ Sinus problems |
| ☐ Sore throat | ☐ Speech Difficulty | |

Psychiatric (CHECK ONLY IF YES)

- ☐ Anxiety ☐ Depressed mood

Genitourinary (CHECK ONLY IF YES)

- ☐ Abdominal pain/swelling ☐ Frequent urination
☐ Painful urination ☐ Blood in urine

Past Medical History (check all that apply)

- ☐ High blood pressure
☐ Diabetes (Type ☐1 ☐2)
☐ Stroke
☐ Cancer (type): _____
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Scoliosis
☐ Thyroid disease
☐ Vertigo
☐ Bleeding disorder
☐ HIV/AIDS
☐ Hepatitis
☐ Pacemaker / Defibrillator
☐ Other: _____

Problem Areas

***Denotes required information**

***Describe your problem:**

***On a scale of 0-10, rate your intensity: Lowest - 1 2 3 4 5 6 7 8 9 10 - Highest**

***How did your problem begin:**

*When did your problem begin? (**exact date if possible**)

How often do you experience symptoms: _____

How would you describe your symptoms?

- | | | |
|---------------------------------|------------------------------------|-----------------------------------|
| ☐ Dull | ☐ Stabbing | ☐ Tingling |
| ☐ Aching | ☐ Shooting | ☐ Weakness |
| ☐ Deep | ☐ Cramping | |
| ☐ Sore | ☐ Spasm | |
| ☐ Stiff | ☐ Throbbing | |
| ☐ Tight | ☐ Burning | |
| ☐ Sharp | ☐ Numbness | |

Does it radiate, shoot, or travel to other areas of your body? ☐ Yes ☐ No

If so, to what areas does the pain radiate, shoot, or travel?

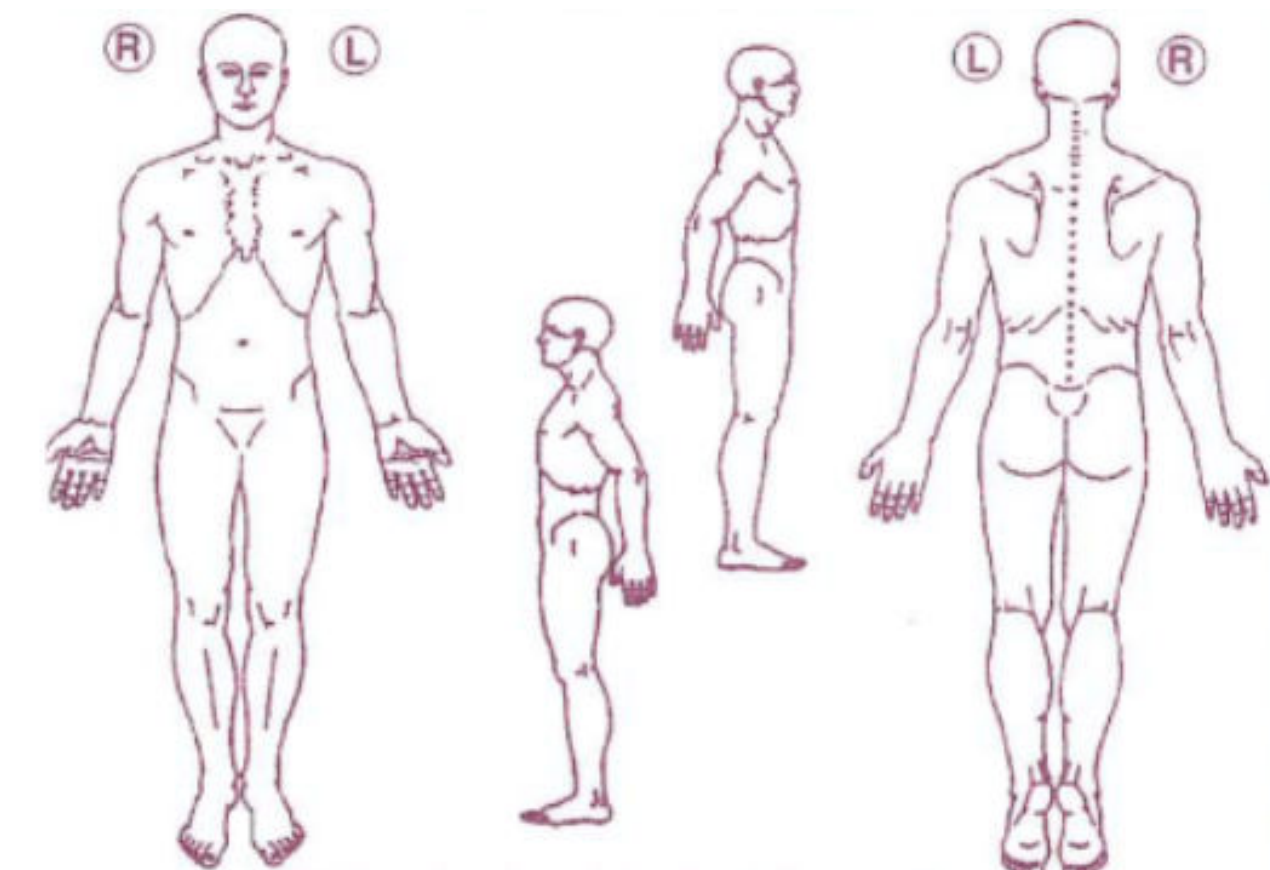
What makes it **better**? (Times of day, movements, activities, etc):

What makes it **worse**? (Times of day, movements, activities, etc):

What have you done to relieve the symptoms?

- | | |
|--|--|
| ☐ Ice | ☐ Chiropractic Adjustment |
| ☐ Heat | ☐ Physical Therapy |
| ☐ Rest | ☐ Injections |
| ☐ Sitting | ☐ Surgery |
| ☐ Lying down | ☐ Other: _____ |
| ☐ Stretching | |
| ☐ Exercise | |
| ☐ Prescription Medication | |
| ☐ Over the counter medication | |
| ☐ Massage | |
| ☐ Acupuncture | |

Location of Symptoms



The diagram shows three human figures for symptom location: a front view, a side view, and a back view. The front view has 'R' (Right) and 'L' (Left) labels above the head. The back view has 'L' (Left) and 'R' (Right) labels above the head. The side view is positioned between the front and back views. Below the figures is a horizontal scale from 1 to 10, with 'Least' at 1, 'Moderate' at 5, and 'Most' at 10. The scale is marked with dashed lines between numbers.

Grade Symptom Level For Each Area of Complaint.

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Least Moderate Most

Patient/Legal Guardian Signature: _____

Print Name: _____

Date: _____