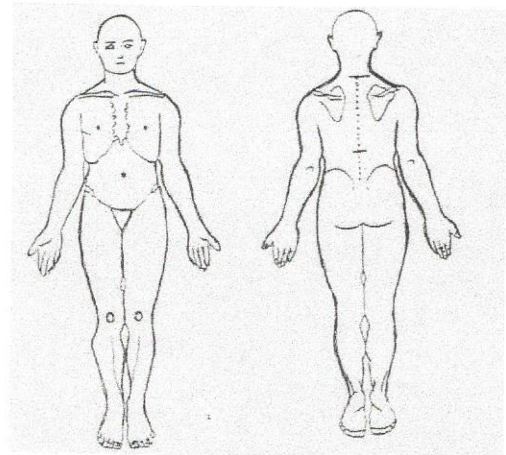
Active Life Chiropractic & Massage Center
Chief Complaint Form
(Most important form, please be complete)

__New Patient __Reactivate __ New Episode __Aggravation __Other

+++ Burning
(((Aching Pain
>>> Pins & Needles
000 Numbness
:::: Sharp Pain
XXX Dull/Crampy



1. **Name:** ________________________________
2. **Date:** ________________________________
3. **Chief complaint (please put primary 2 concerns only and also mark diagram):**
   1.____
   2.____
4. **What was cause of injury (How did it happen)?**
   1.____
   2.____
5. **When approximately did this issue begin?**
   1.____________________ 2. ____________________
6. **Who have you seen for your current symptoms?**
   __No One __ Physical Therapist __ Medical Doctor __ Chiropractor __ Other__________
   a. What treatment(s) did you receive (core, injections, meds, braces, etc)__________________________
   b. What was outcome (reduce symptoms, temporary, etc)? __________________________
7. **Frequency of Symptoms:** 1. ___Constant (76-100%) ___Frequent(51-75%) ___Occasional(26-50%)___Intermittent(<25%)
   2.___Constant (76-100%) ___Frequent(51-75%) ___Occasional(26-50%)___Intermittent(<25%)
8. **What makes condition worse (positions, activity, etc)?**
   1.____________________ 2.____________________
9. **What makes condition better (meds, ice/heat, positions, past PT, etc)?**
   1.____________________ 2.____________________
10. **Previous episodes/significant trauma in same area?**
    1.____________________ 2.____________________
11. **Tests Performed for Condition: Test, date, result**
    (MRI, Xray, CT, Ultrasound and what results)
    a.____
    b.____
    c.____
    d.____
12. **On a scale of 1-10 with 10 being unbearable, rate your current level of complaint:**

	(Barely Noticeable)			(moderate nag)			(unbearable)			
Condition #1	1	2	3	4	5	6	7	8	9	10
Condition #2	1	2	3	4	5	6	7	8	9	10

13. **Any changes in medical or surgical history since last visit?**
    ____
14. **Any urgency involved in your issue (work trip, race, loss of sleep, etc)?**
    ____
    ____
    ____

ACTIVITIES OF DAILY LIVING

Indicate Your Ability to Perform the Following Activities. Please Use These Codes.

U-Unable **L**-Limited **P**-Painful **D**-Difficult **N**-Normal **H**-Haven't Tried

1.___Lying on Back
2.___Lying on Side
3.___Lying Flat on Stomach
4.___Turning Over in Bed
5.___Getting In/Out of Car
6.___Reaching
7.___Gripping
8.___Climbing
9.___Pulling
10.___Dressing Self
11.___Sexual Activity
12.___Sleeping
13.___Pushing
14.___Kneeling
15.___Stooping
16.___Sitting (work,home)
17.___Bending Forward
18.___Walking Short Distances
19.___Bending to Brush Teeth
20.___Standing 1+ hours
21.___Balancing
22.___Cough/Sneeze/Grunt
How?___________
Where?___________

23.___Other___________ 24.___Other___________ 25.___Other___________

FILL OUT NEXT SECTIONS AS THEY APPLY TO YOU

HEADACHE

Yes No

Do You Experience:

___ ___ Nausea, Vomiting, or Visual Disturbances?
___ ___ Radiation (travel) of Pain from Neck?
___ ___ Pain/Clicking in Jaw?
___ ___ Abnormal Blood Pressure?
___ ___ Family History of Headaches?

Frequency of Headaches:___________

Date of Last Eye Exam: ____/______

LUMBOSACRAL SPINE (Lowback)

Yes No

___ ___ Feeling of Ripping or Tearing?
Where?___________
___ ___ Does the Pain Radiate (travel) to the Abdomen?
___ ___ Does the Pain Radiate (travel) into the Leg?
___ ___ Impairment of Bowel or Bladder Function?
Explain:___________

CERVICAL SPINE (Neck)

Yes No

___ ___ Neck Injury that Affects Hearing, Vision, Balance or Causes Ringing in Ears?
___ ___ Do You Hear Grating Sounds?
___ ___ Is Your Swallowing Affected?

Yes No

___ ___ Difficulty Turning Head? __Right __Left
___ ___ Pain/Pressure Behind Eyes?
___ ___ Feeling of Ripping/Tearing
Where?___________

During the past <u>4 Weeks</u>, how much has the pain interfered with your work (including housework, job, etc)?

__Not at all __ Little bit __ Moderately __Quite a bit __ Extremely

During the past <u>4 Weeks</u>, how much has the pain interfered with your Social Life?

__Not at all __ Little bit __ Moderately __Quite a bit __ Extremely

CONSTITUTIONAL

Height:________

Weight:_______

BMI:__________

Heart Rate:______

Quality:_______

Blood Pressure:______/______

Respirations:________

Pulse Ox:______