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Patient Name: _____

Date: _____

Place an (x) by the symptoms you are experiencing, and a #, 0-10 with 10 being the maximum pain possible by each of the pain symptoms

- () Headache _____
 - () Knee pain _____
 - () Neck pain _____
 - () Jaw pain _____
 - () Shoulder pain _____
 - () Visual Problems _____
 - () Upper back pain _____
 - () Dizziness _____
 - () Mid back pain _____
 - () Memory problems _____
 - () Lower back pain _____
 - () Difficulty concentrating _____
 - () Chest pain _____
 - () Arm/wrist/hand pain _____
 - () Sleeplessness _____
 - () Arm/wrist/hand numbness _____
 - () Leg pain _____
 - () Change in bowel/bladder habits _____
 - () Leg numbness _____

 - () List other symptoms _____
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1. Have you seen any other doctors for this condition(s)?
Name of Doctor _____ Date of last treatment _____
2. List all medications currently using? _____
3. List all allergies _____
4. List any family members, including yourself, that have suffered from:
Heart Disease _____
Diabetes _____
Hypertension _____
Cancer _____
Other named conditions _____
5. List any previous head or spine injuries _____
6. List previous surgeries _____

The above information is accurate: Signed _____ Date _____