

Last name

First name

PLEASE COMPLETELY FILL IN THE **ONE** CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- | | | | |
|--|--------------------------------|-----------------------------|--------------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Shoulder | <input type="radio"/> Hip | <input type="radio"/> Headache |
| <input type="radio"/> Upper/
mid back | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Other |
| <input type="radio"/> Lower back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | |
| | <input type="radio"/> Hand | <input type="radio"/> Foot | |

2. When did this problem first begin?

- ☐ Less than 1 month ago ☐ 1-3 months ago ☐ 4-6 months ago ☐ 7-12 months ago ☐ More than 1 year ago

Has this problem...

No Yes

3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?

☐ ☐

4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?

☐ ☐

5. ... recently been evaluated by a medical doctor?

☐ ☐

Since this problem began, have you noticed...

No Yes

6. ... so much weakness in both your arms that you are unable to lift them?

☐ ☐

7. ... so much weakness in both your legs that you are unable to walk without help?

☐ ☐

8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?

☐ ☐

9. ... pain in your chest, shortness of breath, or coughing up blood?

☐ ☐

10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?

☐ ☐

Have you recently...

No Yes

11. ... had blurred vision, double vision, dizziness, or fainting?

☐ ☐

12. ... had any type of infection, fever, or chills?

☐ ☐

13. ... had any type of surgery, surgical procedure, or medical procedure?

☐ ☐

14. ... lost a lot of weight without really trying to (i.e. without being on a diet)?

☐ ☐

15. ... had any type of accident, fall, or trauma?

☐ ☐

Have you ever...

No Yes

16. ... been diagnosed with cancer?

☐ ☐

17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?

☐ ☐

18. ... been diagnosed with a weakened immune system?

☐ ☐

19. ... used any injected drugs (i.e. non-prescription drugs)?

☐ ☐

20. ... used steroids such as prednisone for more than 4 weeks?

☐ ☐

Is this problem something that ...

No Yes

21. ... you've had before?

☐ ☐

22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise?

☐ ☐

23. ... generally gets better (i.e. less severe or frequent) with rest?

☐ ☐

24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?

☐ ☐

25. ... is also being treated by a health professional other than a chiropractor?

☐ ☐

Service Date:

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