

Please Mark your areas of pain on the figures shown below

Date: \_\_\_\_\_

**PATIENT SYMPTOMS**

Patient's Present Symptoms: \_\_\_\_\_

\_\_\_\_\_

Additional Symptoms: \_\_\_\_\_

\_\_\_\_\_

Recent Falls: \_\_\_\_\_ Recent Accidents: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Other Illness: \_\_\_\_\_

Medication Being Taken: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

First Chiropractic Treatment: [ ] Yes [ ] No

Patient Comments: \_\_\_\_\_

\_\_\_\_\_

Check Symptoms You Have Noticed:

- [ ] Headache    [ ] Dizziness    [ ] Light Hurt Eyes    [ ] Diarrhea    [ ] Head seems Heavy    [ ] Memory Loss
- [ ] Neck Pain    [ ] Feet Cold    [ ] Hands Cold    [ ] Ears Ring    [ ] Pins/ Needles – Arms    [ ] Stomach Upset
- [ ] Neck Stiff    [ ] Nervousness    [ ] Face Flushed    [ ] Buzzing Ear    [ ] Pins/Needle – Leg    [ ] Constipation
- [ ] Back Pain    [ ] Lack Sleep    [ ] Loss of Balance    [ ] Cold Sweats    [ ] Numbness — Fingers    [ ] Fainting
- [ ] Tension    [ ] Short Breath    [ ] Loss of Smell    [ ] Fever    [ ] Numbness — Toes    [ ] High Blood Pressure
- [ ] Irritability    [ ] Fatigue    [ ] Loss of Taste    [ ] Depression    [ ] Chest Pain

Additional Symptoms Not Listed: \_\_\_\_\_

Patient's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_