TECUMSEH CHIROPRACTIC CENTER, INC

402 E CHICAGO BLVD - TECUMSEH, MI 49286 - (517) 423-7414

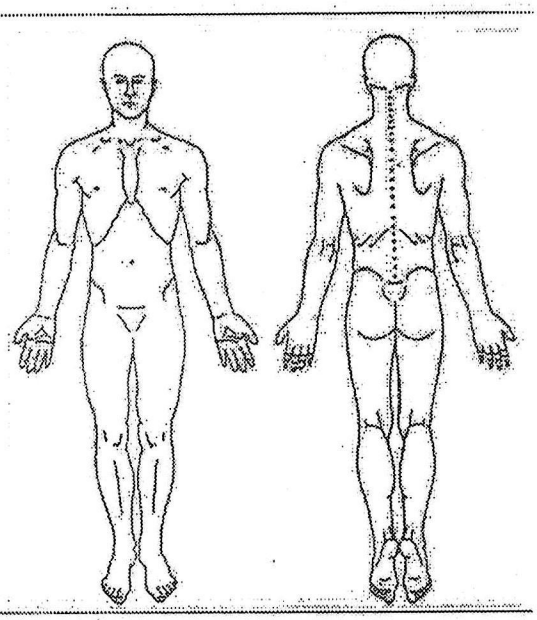
Name: Date:

What is your chief complaint ?

_____

Indicate the location of the pain or problem:

Instructions: On the body diagrams to the right, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



Quality: How would you describe the pain or symptom ?
(Circle all that apply)

Aching	Dull	Pulsating	Stabbing	Tightness
Burning	Excruciating	Radiating	Stiffness	Weakness
Cramping	Numbness	Sharp	Throbbing	
Diffuse	Pounding	Shooting	Tingling	

Severity: On a scale of 0 to 10, with 10 being the worst possible, how would you rate your pain or problem ?

Now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

Onset: Describe how and when it began: _____

_____

_____

How often are you experiencing it ? (Circle one)

Infrequently	Occasionally	Intermittently	Frequently	Constantly
(less than daily)	(1/4 of the time)	(1/2 of the time)	(3/4 of the time)	(90-100% of the time)

What makes it better ? (Circle all that apply)

Activity	Massage	Pain meds	Nothing
Heat	Standing	Sitting	Immobilization
Ice	Walking	Stretching	
Elevation	Resting	Movement	

Other: _____

What makes it worse ? (Circle all that apply)

Pushing	Bending	Kneeling	Nothing
Pulling	Sitting	Lying down	Weight bearing
Movement	Standing	Coughing	Looking up
Driving	Lifting	Sneezing	Looking down

Other: _____

Describe any other symptoms related to this problem: _____

_____

_____

What have you done for this problem before coming in today ? (Circle all that apply)

Bed rest	Massage	Exercise	Nothing
Heat	Pain meds	Hot showers	Topical Ointment
Ice	Traction	Chiropractic	Family MD

Other: _____

What functional activities are affected by this problem ? _____

_____

_____

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NAME: _____ HEIGHT: _____ WEIGHT: _____

PREVIOUS ILLNESSES AND MAJOR INJURIES

PLEASE LIST ANY PREVIOUS ILLNESSES AND MAJOR INJURIES:

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

SURGERIES AND HOSPITALIZATION

PLEASE LIST ANY SURGERIES AND HOSPITALIZATIONS:

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

MEDICATIONS AND SUPPLEMENTS

PLEASE LIST ALL MEDICATIONS, NUTRITIONAL SUPPLEMENTS(S), VITAMINS(V), AND OVER THE COUNTER DRUGS(OTC):

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

ALLERGIES

PLEASE LIST ALL KNOWN ALLERGIES:

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

HAS ANY RELATIVE EVER HAD THE FOLLOWING? (Please circle)

HEART PROBLEMS	Father	Mother	Sister	Brother	Other
HIGH BLOOD PRESSURE	Father	Mother	Sister	Brother	Other
ARTHRITIS	Father	Mother	Sister	Brother	Other
DIABETES	Father	Mother	Sister	Brother	Other
STROKE	Father	Mother	Sister	Brother	Other
CANCER	Father	Mother	Sister	Brother	Other
OSTEOPOROSIS	Father	Mother	Sister	Brother	Other
BLOOD CLOTS	Father	Mother	Sister	Brother	Other

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment status: ☐ Employed ☐ Homemaker ☐ Self employed ☐ Retired ☐ Unemployed ☐ Student

Domicile: ☐ Live alone ☐ Live with spouse ☐ With parents ☐ With children ☐ Assisted living

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously, but quit_____ ☐ Current packs/day_____

Use of drugs: ☐ Never ☐ Type/frequency_____