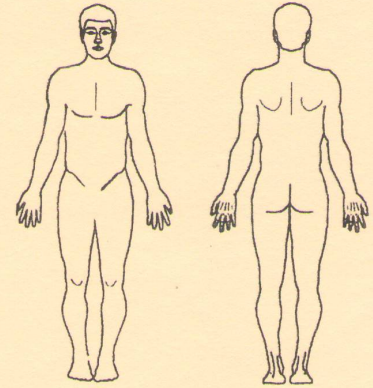


MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM: _____

Date Problem Began _____

How Problem Began _____



Current complaint (how you feel today):

0	1	2	3	4	5	6	7	8	9	10
No pain										Unbearable pain

How often are your symptoms present?
 (Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

	0	1	2	3	4	5	6	7	8	9	10
No interference											Unable to carry on any activities

In general would you say your overall health right now is:
 Excellent Very Good Good Fair Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?
 No Yes Date(s) Taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks _____ |
| <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Use-Type _____ |
| <input type="checkbox"/> Other Health Problems (Explain) _____ | Frequency _____ /Day |
| | <input type="checkbox"/> Medications _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician if necessary.

Robert Hollingsworth, D.C.
 Pacific Chiropractic Clinic
 1140 NE Highway 101
 Lincoln City, OR 97367

Patient Initials _____ Date _____

541-994-4093