LEMONT ACTIVE CHIRO

15947 W. 127th St., Ste. G, Lemont, IL 60439

Name: _____ Date:_____

What are your symptoms?
(Select symptoms on line A, B, or C only. Use additional sheets if necessary.)

A: □ Neck Pain □ Radiate L or R Arm? □ Headache

B. □ Low Back Pain □ Radiate L or R Leg? □ Mid-Back Pain

C. □ Other_____

Dr.Notes:_____

Dominant Hand: □ Right □ Left □ Ambidextrous

Describe symptoms:
1. pain_____ numbness_____ tingling_____ stiffness _____ pinching _____
   burning_____ dull_____ sharp_____ aching_____ throbbing_____
   other _____
2. worsening_____ improving_____ unchanged_____

Dr.Notes:_____

Pain Scale: (circle) No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
Dr. Notes:_____

What percentage (%) of the time you are awake do you experience the above symptom?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did your symptoms begin? Month_____ Day_____ Year_____
Dr.Notes: Acute / Chronic_____

How did your symptoms begin? □ suddenly □ gradually □ unknown
Dr.Notes:_____

What caused your symptoms? □ unknown □ home accident □ auto accident
□ work injury □ sports injury □ other _____
Please describe:_____
Dr.Notes:_____

When are your symptoms worse? □ morning □ afternoon □ evening

What makes your condition worse? □ nothing □ bending □ coughing □ sneezing
□ lifting □ walking □ sitting □ standing □ sit to stand
□ twisting □ reaching □ changing positions □ turning over (bed)
□ other _____

What makes your condition better? □ nothing □ rest □ sitting □ stretching
□ exercise □ standing □ ice □ heat □ medications
□ other _____

Have you had any professional treatment for this episode? ☐ yes ☐ no
Describe: (date, doctor seen, treatment and results)

_____
_____
_____
Dr.Notes:_____
_____
_____

What does your condition prevent you from doing?
Describe: (**PLEASE BE SPECIFIC**.)

_____
_____

Have you ever had this condition before? ☐ no ☐ yes Previous episodes: 1-5 6-10 11+
Describe: (date, doctor seen, treatment and results)

_____
_____
Dr.Notes:_____
_____

What home treatments have you tried?

Ice	*helped*	*no help*	(circle one)
Heat	*helped*	*no help*	
Medication	*helped*	*no help*	

Other_____
Describe_____

Have you noticed a change in: bowel function ☐ yes ☐ no
bladder function ☐ yes ☐ no
Describe:_____
_____

Describe your sleep habits: Position: _____
Pillows (# , type): _____
Mattress (type, age): _____

Explain your job/employment.

_____
_____

Have you missed any work due to this condition? ☐ yes ☐ no
Is yes, please explain and give dates:

_____
_____

Is there a family history of your condition? ☐ yes ☐ no
If yes, please describe:

_____
_____

Dr._____