Patient Name:_____

DOB:_____ Date:_____

What symptoms are you suffering with?	How long have you had it?	What does it feel like? (i.e. aching, burning, stabbing.)
1. **(Chief Complaint)**		
2.		
3.		

First or Chief Complaint.

Is there an earlier accident/injury/repetitive motion that is related to these problems? (i.e. fall, auto injury, work injury, sports injury, repetitive motion on the job)

_____

_____

Since the time you began suffering with this problem, what have you tried? (i.e. ice, heat, rest, over the counter meds, prescriptions, physical therapy, chiropractic, other)

_____

_____

What activities do you have trouble doing because of the symptoms?

_____

_____

Looking to a few years from now, what are those things you wish to be doing more of? (i.e. travel, relationship, work, physical)

_____

_____

On a scale of 1-10, ten being the highest, rate your commitment to getting rid of the problem. _____

Is there anything preventing you from getting this problem taken care of?_____

_____