Chagrin Valley Chiropractic and Acupuncture Center, LLC

Patient Name________________________________ **Date**_____________

History of Chief Complaint (please be specific as possible):

Reason for visit:

#1______________________________ #2______________________________ #3______________________________

Date of onset:

#1________________ #2________________ #3________________

How did illness(es)/injury(ies) occur____

____

____

____

Do the symptoms radiate anywhere?(please describe and also use the attached pain diagram)______________________

____

Please rate symptoms on scale of 0-10 (0=no pain/discomfort 10=worst pain/discomfort ever experienced)

#1 Initially: /10 Currently: /10 At its worst: /10 At its best: /10

#2 Initially: /10 Currently: /10 At its worst: /10 At its best: /10

#3 Initially: /10 Currently: /10 At its worst: /10 At its best: /10

What makes symptoms worse____

____

____

What makes symptoms better____

____

Do the symptoms get better or worse at any time? (morning, evening, etc)______________________________

____

Are the symptoms getting progressively worse or better?____

____

Are there any other symptoms that you have noticed since the onset of the chief complaint?____________________

____

Does this complaint interfere with your(check all that apply): ☐Work ☐Recreation ☐Sleep ☐Basic activities of daily living. Please use this area for further description of the above if needed:______________________________

____

Have you seen anyone else for this condition? ☐No ☐Yes – If yes describe below

Name of doctor/practitioners____

Treatment(s) performed____

Did it help?____

What are your goals of treatment at this office?____

____

______________________ ______________ ______________________ ______________

Patient Signature **Date** **Dr Signature** **Date**