**Chiropractic History of Present Illness**

| **Major Complaint** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Secondary Complaint(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What happened?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MVA Claim**: **O** Yes **O** No

**Which daily activities are being affected by this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **MAJOR COMPLAINT**   | ***Location of Symptoms & Radiation***  ***R***    *R L L L R*  ***P\_ Pain T\_ Tender .***  ***N\_ Numb S\_ Spasms .***  ***H\_Hypoesthesia (*loss in sensation)** | **Quality:**   * Sharp * Stabbing * Burning * Achy * Dull * Stiff & sore * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **Does it radiate?**  **O** Yes  **O** No (please indicate on the drawing)  **Improves with:**   * Ice * Heat * Movement * Stretching * Over-the-Counter Medications: \_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Grade Intensity/Severity:**   * None (0/10) * Mild (1-2/10) * Mild Moderate (2-4/10) * Moderate (4-6/10) * Moderate Severe (6-8/10) * Severe (8-10/10)   **Frequency:**   * Acute (Suddenly from injury) * Intermittent (Off & On) * Chronic (Constant)   **Worsens with:**   * Sitting * Standing * Walking * Laying down/Sleeping * Lifting/Overuse * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | --- | --- | --- | |
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| **\**Women*:** Are you Pregnant?   * No ***Last Menstrual Period:***  *\_\_\_\_/\_\_\_\_/\_\_\_\_\_* * Yes ***Due Date*** *\_\_\_\_/\_\_\_\_/\_\_\_\_\_*   **Previous Treatment(s)**   * None * Chiropractor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Medical Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Physical Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * ER/ Urgent Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Orthopedic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Previous Diagnostic Testing(s)**   * None * X-Rays \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * MRI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * CT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   ***Present Illness Comment(s):***  ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | **Prescription Medications & Supplements**   * None * Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Allergies to Medication**   * No known drug allergies * Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Account #:\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_ |
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