

New Patient Core Priority Re-activation Consultation Last X-ray : _____ Last Adj. : _____

Patient Name: _____ ID #: _____ Date: _____ CA GI MC PI WC

Problems/ complaints/ symptoms that BROUGHT PATIENT IN (On History Form)

Neck Pain Upper Back Pain Mid back Pain Low back pain Hip Pain L R Shoulder L R Wrist L R Knee L R
 Ankle L R Headaches/Migraines

Symptoms/health conditions identified by patient RELATED TO THEIR SPINAL REGION OF PAIN:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest Pain/Short of breath
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Heart Palpation/Murmur
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Stomach/Digestive Problem
<input type="checkbox"/> Sinuses/Allergies	<input type="checkbox"/> Cold/Burning/Itchy hands	<input type="checkbox"/> Asthma/Upper Resp.
<input type="checkbox"/> Ringing/Buzzing Ears	<input type="checkbox"/> Depression	<input type="checkbox"/> Recurring Bronchitis/Pneumonia
<input type="checkbox"/> Pain Behind Eyes/ Blurred vision	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Heartburn/Indigestion
<input type="checkbox"/> Sore Throat/Throat Infections	<input type="checkbox"/> Numb/Tingling/Weak to arms	<input type="checkbox"/> Ulcers/Acid Reflux
<input type="checkbox"/> Difficulty Getting Pregnant/Impotence	<input type="checkbox"/> Gassy/Bloating	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Pain/Numb/Tingling/weak down legs	<input type="checkbox"/> Other	<input type="checkbox"/> Freq. Urination/Urinary Infection
<input type="checkbox"/> Excess Gas	<input type="checkbox"/> Cramping in legs/toes/feet	<input type="checkbox"/> Burning/Itchy/Swelling Feet
<input type="checkbox"/> Cramping/Irreg. Periods		

How did your condition develop? (Did it come gradually from an activity, event or injury?) DOI/DOL _____

When was the first time in your life you ever had the same or similar problem? Please Explain _____

How many times have you experienced it since the first time it happened? _____

Is the frequency, intensity or length of time the condition last has gotten Worst or the Same? Please Explain _____

When it is at its worst, describe how it feels: Sharp Dull Achy Burning Stabbing Limited & Painful
 Numbness/tingling Annoyance Weak Heavy Feeling Throbbing Debilitating Other _____