

Primary Complaint Form

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KLINGERT CHIROPRACTIC

(602) 843-3788

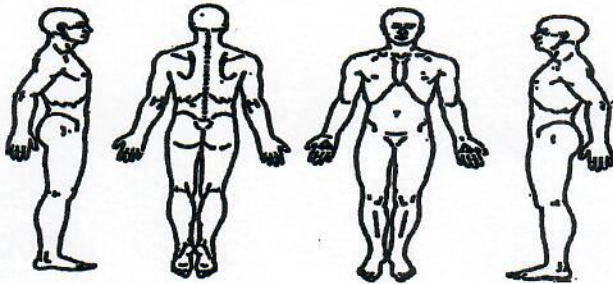
Patient Name: _____ File#: _____ Date: _____

What is your: Height _____ Weight _____ Date of Birth _____ Age _____
Occupation _____

Is today's problem the result of specific incident? (Explain) _____

Auto Accident Workman's Compensation Other _____

Indicate on the drawings below where you have your WORST problem and answer the following questions about that problem:



WORST AREA OF COMPLAINT: _____

(L / R = Left / Right)

- | | | | | | |
|--|---|---|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | (<input type="checkbox"/> Entire Head | <input type="checkbox"/> Base of Skull | <input type="checkbox"/> Forehead | <input type="checkbox"/> Temples) | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Neck L / R | <input type="checkbox"/> Shoulder L / R | <input type="checkbox"/> Elbow L/R | <input type="checkbox"/> Hand L / R | | |
| <input type="checkbox"/> Mid Back L / R | <input type="checkbox"/> Upper Mid Back L / R | <input type="checkbox"/> Lower Mid Back L / R | <input type="checkbox"/> Rib Cage L / R | | |
| <input type="checkbox"/> Low Back L / R | <input type="checkbox"/> Hip L / R | <input type="checkbox"/> Knee L / R | <input type="checkbox"/> Foot L / R | | |
| <input type="checkbox"/> Other L / R _____ | | | | | |

1. Using a scale from 0-10 (10 being severe, tearful type pain), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)
None Mild Moderate Severe Tearful

2. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> Intermittently (1-25% of the time) |

3. How would you describe the type of pain?

- | | | |
|---|---|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Stabbing with motion | <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric-like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ | |

4. How are your symptoms changing with time?

- | | | |
|--|---|---|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |
|--|---|---|

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Name: _____ File#: _____

5. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

6. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

7. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician ER physician Orthopedist
 Massage Therapist Physical Therapist No one Other: _____
Diagnosis _____ Results _____

8. How long have you had this problem? _____

9. How do you think your problem began?

10. Do you consider this problem to be severe? Yes Yes, at times No

11. What aggravates your problem? (L / R = Left / Right)

- | | | | |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Bend Forward | <input type="checkbox"/> Walking | <input type="checkbox"/> Running |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Bend Backward | <input type="checkbox"/> Sitting | <input type="checkbox"/> Climb Stairs |
| <input type="checkbox"/> Straining | <input type="checkbox"/> Rotation L / R | <input type="checkbox"/> Lying | <input type="checkbox"/> Quick Movements |
| <input type="checkbox"/> Bowel Movement | <input type="checkbox"/> Side Bending L / R | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting _____ pounds |
| <input type="checkbox"/> Work at Computer | <input type="checkbox"/> Other _____ | | |

12. What makes the problem better?

- | | | | |
|---|-------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Stretching | <input type="checkbox"/> Heat | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Ice | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Prescription Medications | | <input type="checkbox"/> Over the Counter Medications | |
| <input type="checkbox"/> Other _____ | | | |

13. What concerns you the most about your problem; what does it prevent you from doing?

- | | |
|---|--|
| <input type="checkbox"/> It could be serious. | <input type="checkbox"/> It is affecting leisure activity. |
| <input type="checkbox"/> It isn't going away. | <input type="checkbox"/> It is affecting work. |
| <input type="checkbox"/> It is getting worse. | <input type="checkbox"/> Other _____ |

14. Have you ever had this problem before? Yes / No

Please describe _____

I hereby state that the information on this form is true and correct. I authorize the Doctors at the Center to examine, take x-rays and treat me for the care and management of my condition.

Patient Signature _____ Date: _____

I hereby give permission to administer treatment as deemed necessary for the care of my child,

(Print child's name) _____ Birthdate: _____ Parent's Signature: _____