KLINGERT CHIROPRACTIC (602) 843-3788

Patient Name: ______________________ **File#:** ________ **Date:** ______________

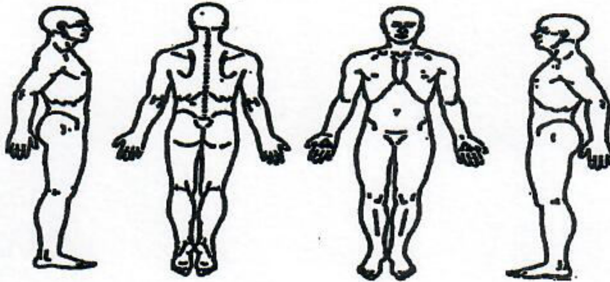
What is your: Height__________ **Weight** ___________ **Date of Birth** ______________ **Age** ______
Occupation ______________________________

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)**

□ Head (□ Entire Head □ Base of Skull □ Forehead □ Temples) □ Migraine
□ Neck L / R □ Shoulder L / R □ Elbow L/R □ Hand L / R
□ Mid Back L / R □ Upper Mid Back L / R □ Lower Mid Back L / R □ Rib Cage L / R
□ Low Back L / R □ Hip L / R □ Knee L / R □ Foot L / R
□ 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?**
   - □ Constantly (76-100% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Frequently (51-75% of the time)
   - □ Intermittently (1-25% of the time)

3. **How would you describe the type of pain?**
   - □ Sharp
   - □ Numb
   - □ Dull
   - □ Tingling
   - □ Diffuse
   - □ Sharp with motion
   - □ Achy
   - □ Shooting with motion
   - □ Burning
   - □ Stabbing with motion
   - □ Shooting
   - □ Electric-like with motion
   - □ Stiff
   - □ Other:________________

4. **How are your symptoms changing with time?**
   - □ Getting Worse
   - □ Staying the Same
   - □ 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)**
    □ Coughing □ Bend Forward □ Walking □ Running
    □ Sneezing □ Bend Backward □ Sitting □ Climb Stairs
    □ Straining □ Rotation L / R □ Lying □ Quick Movements
    □ Bowel Movement □ Side Bending L / R □ Standing □ Lifting _____ pounds
    □ Work at Computer □ Other ____________________

12. **What makes the problem better?**
    □ Nothing □ Stretching □ Heat □ Rest
    □ Exercise □ Ice □ Sitting □ Standing
    □ Prescription Medications □ Over the Counter Medications
    □ Other __________

13. **What concerns you the most about your problem; what does it prevent you from doing?**
    □ It could be serious. □ It is affecting leisure activity.
    □ It isn't going away. □ It is affecting work.
    □ It is getting worse. □ 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: __________