Achievement Chiropractic

PATIENT HISTORY

NAME: _____

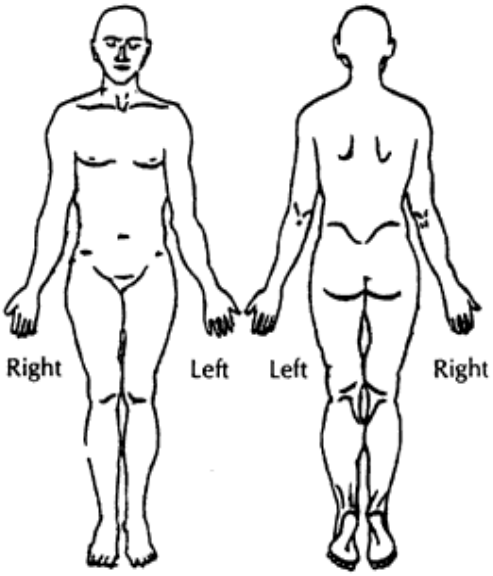
WHAT WOULD YOU LIKE TO SEE IMPROVE?:_____

WHEN DID THIS BEGIN:_____

WHAT, IF ANYTHING MAKES IT BETTER:_____

WHAT, IF ANYTHING MAKES IT WORSE:_____

RATE IMPORTANCE ON A SCALE OF 1 TO 10:_____
1 (Least) 10 (Worst)



TYPE OF PAIN

Sharp	Dull	Throbbing
Tingling	Shooting	Stabbing
Burning	Radiating	Aching
Numbness		

Is pain constant or does it come and go? _____

Please indicate the location of the pain on the figures.

Comments: _____

_____

PLEASE CHECK A HISTORY OF ANY OF THE FOLLOWING:

Headaches	Shoulder Pain	Migraines	Neck Pain
Hip Pain	Numbness, tingling pain in arms, hands or fingers		
Upper back pain/stiffness		Lower back pain/stiffness	

Other _____

Broken bones? If yes, please explain _____

Surgeries? If yes, please explain _____

Hospitalizations? If yes, please explain _____

Current Medical Conditions: _____

Past Medical Conditions: _____

Family Health History: _____

Current Medications/Supplements:_____

Comments: _____

THANK YOU.

Name ____

Date	Subjective Notes	LL	HT	FF	AR	S/P	HELPS	Objective Notes	#1	#2	#3	#4	Additional