A FAMILY & SPORTS CHIROPRACTIC CLINIC

MEDICAL PROFILE CHART # _____

BRIEFLY DESCRIBE YOUR CURRENT PROBLEM: _____

_____

_____

HOW DID THE PROBLEM BEGIN? GRADUALLY _____ SUDDENLY _____

DATE OF ONSET: _____/ _____/ _____

IF THIS PROBLEM BEGAN SUDDENLY, PLEASE DESCRIBE WHAT HAPPENED:

_____

_____

HAVE YOU EVER BEEN TREATED FOR PRESENT CONDITION? NO _____ YES _____ WHEN _____

PLEASE CIRCLE HOW MUCH DISCOMFORT YOU HAVE:

	0= NO DISCOMFORT										10= EXTREME DISCOMFORT
1. RIGHT NOW	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2. AT ITS WORST	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3. AT ITS BEST	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

LIST ANY PAIN OR ANY OTHER MEDICATIONS PRESENTLY TAKING FOR THIS CONDITION:

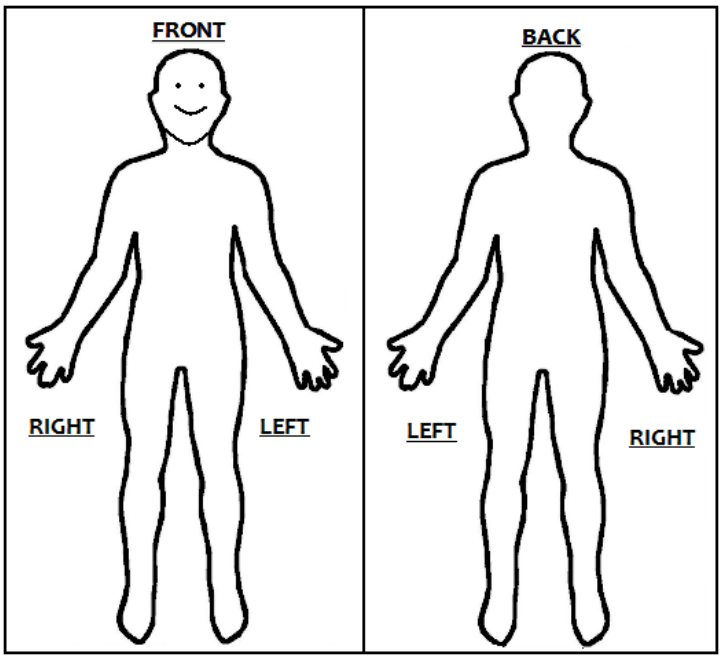
_____

LIST ANY OTHER MEDICATIONS YOU ARE PRESENTLY TAKING:

_____

PLEASE MARK THE LOCATION OF PAIN AND THE SYMBOL THAT BEST DESCRIBES THE DISCOMFORT YOU ARE PRESENTLY EXPERIENCING:

SHARP AND STABBING: +++++++++
DULL AND ACHY: vvvvvvvvv
PINS AND NEEDLES: ooooooooo
NUMBNESS: /////////
BURNING SENSATION: = = = = = =



FOR OFFICE USE ONLY

DATE OF ONSET: _____
CAUSE: _____
TYPE & PATTERN OF PAIN: _____
_____
_____
ACTIVITIES INCREASE PAIN: _____
_____
ACTIVITIES DECREASE PAIN: _____
_____
PAIN RADIATION: _____
PREVIOUS TX: _____
SELF TX: _____

CHART # _____

PLEASE INDICATE BY CHECK MARK HOW THE FOLLOWING FACTORS AFFECT YOUR PAIN:

	INCREASE	NO CHANGE	DECREASE	UNKNOWN
STANDING	_____	_____	_____	_____
WALKING	_____	_____	_____	_____
SITTING	_____	_____	_____	_____
DRIVING	_____	_____	_____	_____
LYING DOWN	_____	_____	_____	_____
SLEEPING	_____	_____	_____	_____
BENDING	_____	_____	_____	_____
KNEELING	_____	_____	_____	_____
LIFTING	_____	_____	_____	_____
PULLING	_____	_____	_____	_____
PUSHING	_____	_____	_____	_____
ARISING FROM A CHAIR	_____	_____	_____	_____
HOUSEWORK (VACUUMING ETC.)	_____	_____	_____	_____
COUGHING	_____	_____	_____	_____
SNEEZING	_____	_____	_____	_____
SOCIAL LIFE	_____	_____	_____	_____
WEATHER CHANGES	_____	_____	_____	_____

PLEASE CHECK ANY HEALTH PROBLEMS THAT APPLY TO YOU:

_____HEART DISEASE _____DIABETES _____LUNG DISEASE
_____HIGH BLOOD PRESSURE _____CANCER _____SEIZURE

ARE YOU A SMOKER? _____YES HOW MUCH PER DAY? _____
_____NO WERE YOU EVER A SMOKER? _____

HEIGHT _____ WEIGHT _____

DESCRIBE OTHER MEDICAL COMPLAINTS: _____

_____

LIST ANY PREVIOUS OPERATIONS: _____

_____

_____ _____
PATIENT SIGNATURE DATE