Name:

Date of Birth:

INITIAL COMPLAINT FORM

1. What is your main complaint?

2. When did it start? Has it gotten better or worse since then?

3. How did it happen? (describe the event)

4. How would you describe the pain? (For example: dull, achy, sharp, deep, superficial, pulling, shooting, stabbing, burning, throbbing, spasms, electric, running water, ants crawling etc)

5. What is the current pain level (0-10)? ___________What is the pain level at its worst (0-10)?__________

6. How often do you notice the pain? (constant, intermittent, “background pain”, episodic , etc)

7. What makes it better? (medication, heat packs, ice packs, rest, lying down etc)

8. What makes it worse? (medication, certain positions, weather, stress, etc) Are there triggers?

9. Have you seen any other doctors for this condition? What was their diagnosis?

10. Have you been to a chiropractor or acupuncturist before? If so, when was your last visit?

11. Did you have any prior diagnostic imaging done? (x ray, MRI, CT etc)

12. Personal medical history (arthritis, blood disease, cancer, diabetes, high blood pressure, high cholesterol, seizures, etc)

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13. Family (mother/father/siblings) medical history (arthritis, blood disease, cancer, diabetes, high blood pressure, high cholesterol, seizures, etc)
14. Any accidents, falls, traumas? (if yes, say when and what happened)
15. Hospitalizations? (surgeries, injuries, giving birth, etc. If so, when and why?)
16. Allergies (seasonal, food, medications, other)
17. Exercise level (how many times/week, what type?)
18. Do you drink alcohol? How often? How many drinks each time?
19. Do you smoke (cigarette, vape, cigar, marijuana)? How often? How many each time?
20. Do you have a special diet? (vegan, paleo, vegetarian, etc)
21. Occupation. How long?
22. Marital Status
23. Children? How many and how old? How is their health?
24. List of current medical conditions previously diagnosed
25. List of current medications, condition each is treating, and dosage