Core Wellness
Chiropractic and Anti-Aging Centre

History of Present Problem

Date____________________

Name____

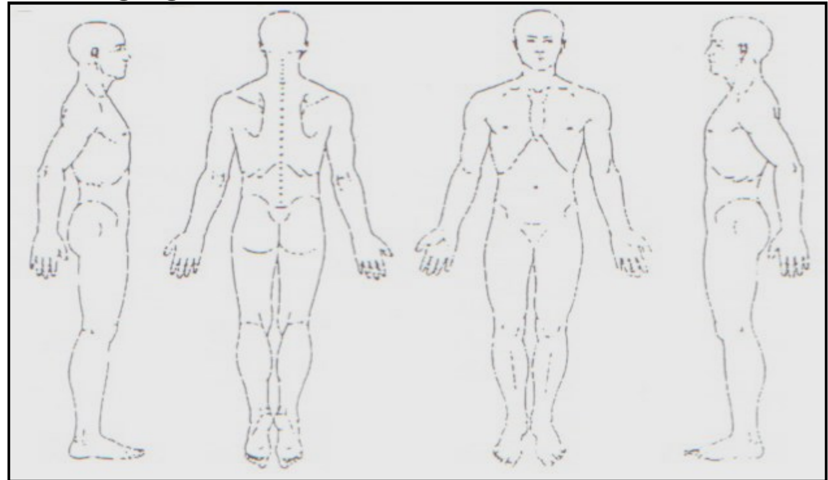
Describe your symptoms___________________________

____

When did your symptoms start?____

How did your symptoms begin?____

Mark an X on the picture where you have pain, numbness or tingling.



Circle what words describe the nature of your pain:

Sharp   Aching   Tingling   Shooting

Dull ache   Stabbing   Burning   Numb

Throbbing   Stiffness   Other_______________

Movements and activities that are painful to perform:

Sitting   Standing   Walking   Bending   Lying down

Your symptoms are:
Getting better   Staying the same   Getting worse

Rate the severity of the pain you are experiencing RIGHT NOW on a scale of 0 to 10 with 0 being no pain and 10 being the most severe pain you have ever had:
1   2   3   4   5   6   7   8   9   10

Rate the severity of the pain when it is at its worst:
1   2   3   4   5   6   7   8   9   10

Rate the severity of the pain when it is at its best:
1   2   3   4   5   6   7   8   9   10

What number is it usually?
1   2   3   4   5   6   7   8   9   10

Circle how often your symptoms are present: Constantly (76%-100% of the day)   Frequently (51%-75% of the day)
Occasionally (26%-50% of the day) Intermittently (0%-25% of the day)

How much has the pain interfered with your normal day?
Not at all   A little bit   Moderately   Quite a bit   Extremely

What makes it better?____

What makes it worse?____

Have you seen anyone for your symptoms? Yes   No   **If yes, what treatment did you receive and when?**
____

What tests have you had for your symptoms?____

Have you had similar symptoms in the past?   Yes   No   **If yes, when did you last have this problem?**
____

How did the problem originally occur?____

If you have received treatment in the past for the same or similar symptoms, what tests were performed and what was your diagnosis?____

Have you ever seen a chiropractor before? Yes   No