Reason For Your Visit – Please write down below anything that you want the doctor to know.

_____

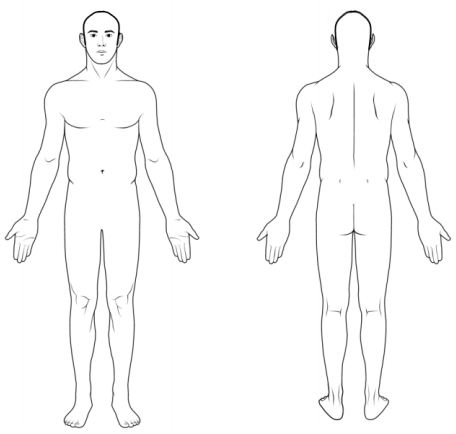
_____

_____

Describe the Pain: ___ Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting
Or sensation ___Burning ___Tingling ___Cramps ___Stiffness ___Swelling ___Other

On the diagram, please mark the areas where you are presently having complaints.

Front Back



Left Right

When did your symptoms begin? _____
How often are symptoms present? Occasional Frequent Constant
It bothers me the most when I: _____

Pain intensity: 0) No pain 1) Mild pain 2) Severe pain 3) Worst possible pain

Sleeping: 0) Perfect 1) Mildly disturbed 2) Moderately disturbed 3) Greatly disturbed 4) Totally disturbed

Personal care (washing, dressing etc.): 0) No pain/no restrictions 1) Mild pain/no restrictions 2) Moderate pain/need to go slowly 3) Moderate pain/need some assistance 4) Severe pain/need 100% assistance

Travel (driving, flying, etc.): 0) No pain/on long trips 1) Mild pain on long trips 2) Moderate pain on long trips 3) Moderate pain on short trips 4) Severe pain on short trips

Work: 0) Can do usual plus unlimited extra work 1) Can do usual/no extra 2) Can do 50% of usual 3) Can do 25% of usual 4) Cannot work

Recreation: 0) Can do all activities 1) Can do most activities 2) Can do some activities 3) Can do a few activities
4) Cannot do any activities

Frequency of pain: 0) No pain 1) Occasional pain 25% of the day 2) Intermittent pain 50% of the day 3) Frequent pain 75% of the day 4) Constant pain 100% of the day

Lifting: 0) No pain with heavy lifting weight 1) Increased pain with heavy weight 2) Increased pain with moderate weight
3) Increased pain with light lifting 4) Increased pain with any weight

Walking: 0) No pain any distance 1) Increased pain after on mile 2) Increased pain after one half-mile 3) Increased pain after one-quarter mile 4) Increased with all walking

Standing: 0) No pain after several hours 1) Increased pain after several hours 2) Increased pain after one hour 3) Increased pain after one half-hour 4) Increased Pain with any standing

Signature: _____ **Date**: _____

KNOBBS CHIROPRACTIC 4305 Beverly St. Suite B Colorado Springs, CO 80918
Phone: 719-528-5656 Fax: 719-582-1134

Name: _____ **Date:** _____

Is today's visit due to: ___Illness ___Accident ___Injury Other _____

Job related? ___Yes ___No Automobile related? ___Yes ___No Other _____

How did your symptoms begin? _____

Medicine/Supplements currently taking? _____

_____

List any surgeries/Injections: _____

_____

Have you been treated for this condition before? ___ Yes ___No if yes by whom? _____

CHRONIC ILLNESSES (Check the disorders that you currently have) fill in the type of condition on the line next to illness

___Alcoholism/Substance Abuse
___AIDS/HIV/ARC
___Anemia
___Cancer _____
___Diabetes
___Emphysema
___Epilepsy or Seizures
___Fibromyalgia
___Gout
___Heart Disease
___Heart Failure
___Hepatitis _____
___Herpes _____
___Hypertension
___Kidney Disease
___Migraine Headaches
___Miscarriages
___Mitral Valve Prolapse
___Multiple Sclerosis
___Polio
___Rheumatic Fever
___Thyroid Disease ___Hypo ___Hyper
___Tuberculosis
___Ulcers

Please Circle The Following Symptoms Which You Have Now Or Check Next To Conditions You Previously had.

General
Convulsions Dizziness or fainting
Environmental allergies
Fatigue easily Headaches
Loss of Balance
Nerve pain Nervousness
Anxiety Night sweats

Muscle/Joint
Arthritis/rheumatism Bursitis
Foot trouble
Low back pain
Neck pain/stiffness
Pain / numb / tingle in: ___Elbow ___Hands ___ Shoulders ___Arms ___ Hip ___Legs ___ Knees ___Feet
Sciatica
Scoliosis
Swollen joints
Tremors
Weakness

Eyes-Ears-Nose-Throat
Deafness or hearing loss
Ear discharge
Ear Noises
Earache or ear pain
Eye infections
Eye pain
Frequent colds
Frequent sore throats
Nasal discharge
Nosebleeds
Sinus Infections

Heart
Chest pain/angina
Hardening of Arteries
Heart attack
High blood pressure
Low blood pressure
Phlebitis
Poor Circulation
Rapid heartbeat
Rheumatic heart disease
Skipped heart beats
Slow heart beats
Swelling of ankles/legs

Gastrointestinal
Abdominal Distention
Constipation Diarrhea
Food Eruption/reflux
Gallbladder trouble
Hemorrhoids
Irritable Bowel Syndrome
Liver Problems
Spastic Colon
Stomach Pain
Ulcer disease

Respiratory Asthma
Chronic cough Difficulty Breathing
Pain when breathing
Shortness of breath
Spitting up blood
Spitting up Phlegm
Wheezing

Women only
Breast Lumps or pain
Excessive Menstrual flow
Menopausal symptoms
Hot flashes
Irregular menstrual cycle
Menstrual cramps

Genitourinary
Bed wetting
Blood in urine
Difficulty urinating
Frequent Urination
Incontinence
Kidney Infection/stones
Painful Urination
Pus in urine
Sexual transmitted disease
_____
_____

Skin
Acne
Easy busing
Eczema
Hives
Rashes
Skin dryness
Skin oiliness
Varicose Veins

Men only
Impotence
Prostate Issues

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