



ARVIDSON CHIROPRACTIC CENTER

379 West Main Street • Tilton, NH 03276 • (603) 286-BACK (2225)

FOR OFFICE USE ONLY

Name _____ Date _____

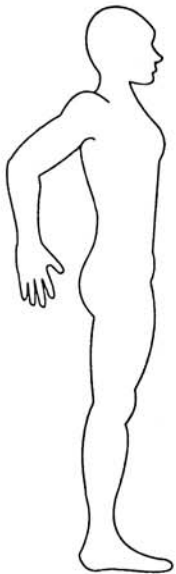
How did the pain begin? _____

When did the pain start, come back or begin to worsen? _____

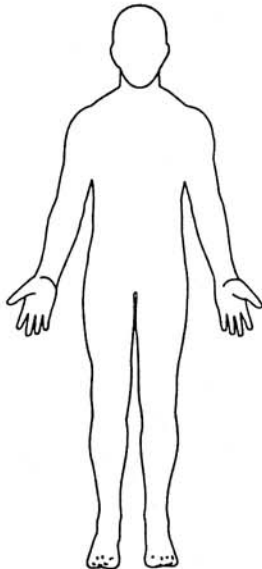
Please describe your pain as accurately as possible. _____

Please indicate location and type of pain on diagram below, using the symbols indicated.

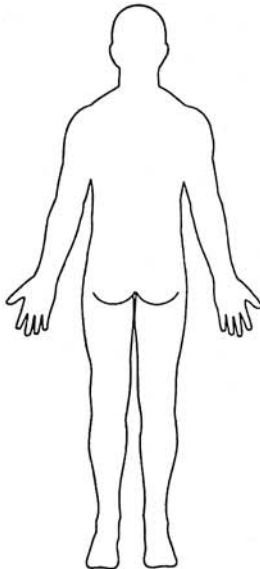
Numbness = N • Tingling = T • Burning = B • Ache = A • Stabbing = S



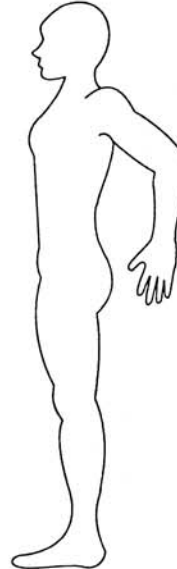
RIGHT



FRONT

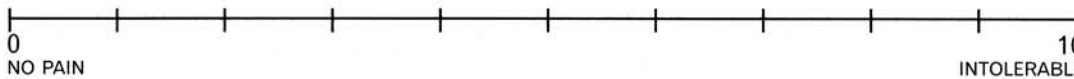


BACK



LEFT

Please indicate severity of pain on the scale below.

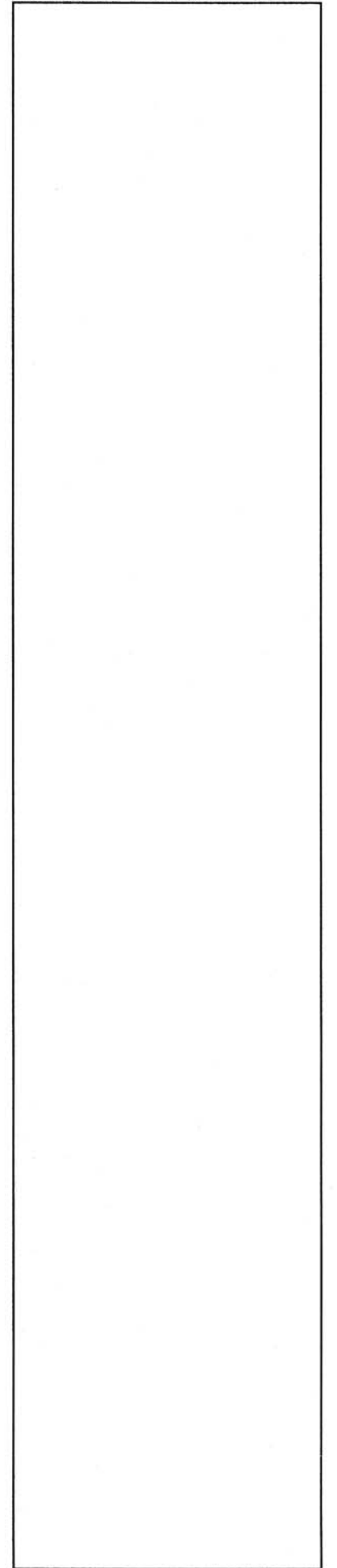


What makes the pain better (medication, stretching, lying down, etc.)? _____

What makes the pain worse (bending, twisting, lifting, etc.)? _____

Does pain travel down arms or legs? Yes No

If yes, where? _____



Is there any time during the day or night when the pain is at its worst (upon rising, after a long day, etc.)? _____

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Is the pain with you constantly or does it come and go? _____

How often is the pain present, and how long does it last? _____

Have you ever had this type of pain before? Yes No

If yes, when? _____

What other types of treatment have you had for this condition? _____

Past Medical History

Have you had any trauma, surgeries or hospitalizations? Yes No

If yes, when? _____

Social History

Occupation _____

Hobbies and Activities _____

Do you drink alcohol? Yes No If yes, how often? _____

Do you smoke tobacco? Yes No If yes, how much? _____

Family History—

is there any history in your family of:

Cancer Relation _____

Heart Disease Relation _____

Diabetes Relation _____

Other illness Relation _____

Please check if you have problems in the following areas:

- | | |
|--|--|
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Nerves |
| <input type="checkbox"/> Ears, nose, mouth, throat | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Lungs/Breathing | <input type="checkbox"/> Internal Organs |
| <input type="checkbox"/> Digestion | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Urinary | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Muscles | <input type="checkbox"/> Other _____ |

I certify that the above statements are true to the best of my knowledge.

Signature _____ Date _____