PATIENT HISTORY

Mid Ohio Chiropractic & Acupuncture

Patient's Name: ________________________ Date: _______________________

What is the primary reason for your visit? ____

____

____

Is injury related to: ☐ Automobile Accident ☐ Work-Related Injury ☐ Personal Injury Case ☐ Others

When did your pain / symptoms begin (includes date, if possible)? ___________________________________

The overall severity of your complaints is: ☐ Mild ☐ Moderate ☐ Severe

The overall frequency is: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (Please circle a number below)

(None ←) 0 1 2 3 4 5 6 7 8 9 10 (→ Worst possible)

If your symptoms change, when are they worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ N/A

Have you had the same or similar problems in the past? ☐ No ☐ Yes, when: _____________________________________

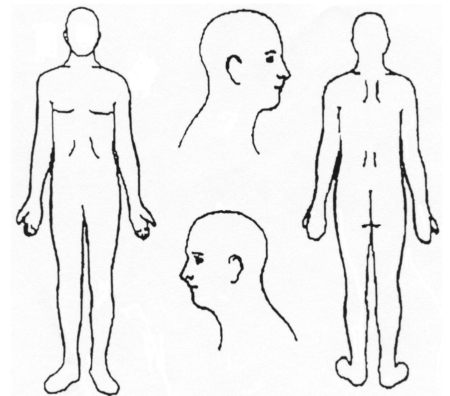
Do you have any additional complaints / concerns/health problems? ☐ No ☐ Yes, ________________________________

What do you prefer? ☐ Traditional Adjustments ☐ Gentle Adjustments with Activator ☐ Acupuncture ☐ Casting
☐ Spinal Decompression ☐ X-rays ☐ Orthotics ☐ Nutritional Counseling

What things are you having trouble to do? ☐ Walking ☐ Sleeping ☐ Standing ☐ Lifting ☐ Bending ☐ Lying ☐ Sitting

What thing do you want to be able to do? ____

Put an "X" where it hurts on the picture: →



If your complaints include pain, how would you describe it?
(Please check all that apply) ☐ Aching ☐ Burning ☐ Dull ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other____________

Since your symptoms began, had you noticed any function changes?
☐ Bowel ☐ Bladder ☐ Sexual ☐ No Changes

Do your work activities aggravate your present complaints?
☐ Yes ☐ No ☐ N/A

Medication

Are you currently taking any prescription or over-the-counter medication: ☐ No ☐ Yes, please provide a list.

Sickness, Injury, and Accident History

(Include **Descriptions**, **Dates,** and specify (**R**)ight side, (**L**)eft side.)

Surgeries / Fractures ____

Auto or Work Injuries ____

Patient's Family History

(Put a check mark where it applies.)

	Living	Deceased	Diabetic	Cancer	Heart	High BP	Scoliosis
Father							
Mother							
Sibling							