HS HealthSource® Chiropractic & Progressive Wellness™

NAME: **DATE:** / / **Account#:**

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent ____Occasional

What caused the onset? _____

_____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

NAME: DATE: / / Account#:

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

Please place a checkmark by the condition that applies to you: **P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • **N** = Not Present • **PP** = If it has ever been present in the past • Do the same for your family
Family History Key: **F** = Father • **M** = Mother • **B** = Brother • **S** = Sister • **GF** = Grandfather • **GM** = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO
Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

❑ Allergic / Immunologic
❑ Constitutional
❑ Endocrine
❑ Gastrointestinal
❑ Genitourinary
❑ Integumentary
❑ Neurological
❑ Respiratory
❑ Cardiovascular
❑ Ears / Nose / Mouth
❑ Eyes
❑ All other system reviews negative
❑ Hematological / Lymphatic
❑ Musculoskeletal
❑ Psychiatric

Notes / Comments: _____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: _____ **DATE:** ____/____/____ **Account#:** _____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____
3. _____ Year_____ 4. _____ Year_____
5. _____ Year_____ 6. _____ Year_____

List any other key slips, falls or accidents you've had from childhood to present:		**Date**
1)		
2)		
3)		
4)		
5)		
What medications are you currently taking? (Include Date)		
1)	**4)**	
2)	**5)**	
3)	**6)**	

Have you ever taken:	**YES**	**NO**	**YEAR**
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: _____

_____

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____