

Collins Chiropractic
619 SW 152nd St, Burien, WA 98166 (206)242-0998

If so, when? _____

9. *What seems to aggravate your condition?*

Nothing Coughing Bending Lifting Walking Reaching Sitting Standing
Pulling Turning Other: _____

10. *What seems to alleviate your condition?*

Nothing Rest Sitting Stretching Exercise Standing Ice Heat Medication
Other _____

11. *How would you characterize your pain (Please circle all that apply)?*

Burning Dull Sharp Shooting Aching Throbbing
Other _____

12. *Does your pain radiate to any of the following areas?*

Left Shoulder	Right Shoulder
Left Arm	Right Arm
Left Hand	Right Hand
Left Buttock	Right Buttock
Left Leg	Right Leg
Left Foot	Right Foot

13. *Are you experiencing any numbness or tingling?* Yes No *If so, where?*

Left Shoulder	Right Shoulder
Left Arm	Right Arm
Left Hand	Right Hand
Left Buttock	Right Buttock
Left Leg	Right Leg
Left Foot	Right Foot

14. *Please rate your pain today on a scale of 0-10*
(0= no pain and 10= your worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

15. *At what time of day are your symptoms worst?*

Morning Afternoon Evening While Sleeping While Awake Other _____

16. *At what time of day are your symptoms best?*

Morning Afternoon Evening While Sleeping While Awake Other _____

17. *How have your symptoms been today?* Better Same Worse

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Please rate your symptoms individually on a scale of 1 to 10 with 0 being no pain and 10 indicating bedridden:

Symptom 1 _____	0 1 2 3 4 5 6 7 8 9 10
Symptom 2 _____	0 1 2 3 4 5 6 7 8 9 10
Symptom 3 _____	0 1 2 3 4 5 6 7 8 9 10
Symptom 4 _____	0 1 2 3 4 5 6 7 8 9 10
Symptom 5 _____	0 1 2 3 4 5 6 7 8 9 10

Who have you seen for this condition?

No One Chiropractor Medical Doctor Surgeon Specialist

What happened to your condition as a result of that treatment?

Resolved Went Unresolved Improved but not to an Acceptable Level Worsened

Who is your Primary Care Physician? _____

Please list any drug allergies: _____

Please list any medications you are currently taking:

Medical History:

Do you have a history of any of the following?

Work Injury Motor Vehicle Accident Slip and Fall Accident

If so, please list approximate dates and incidents:

1) Date _____	Incident _____
2) Date _____	Incident _____
3) Date _____	Incident _____
4) Date _____	Incident _____

Have you ever been hospitalized? Yes No If so, when and for what condition?

1) Date _____	Condition _____
2) Date _____	Condition _____
3) Date _____	Condition _____
4) Date _____	Condition _____

Have you had any surgeries? Yes No If so, when and for what condition?

1) Date _____ Surgery _____

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2) Date _____ Surgery _____
3) Date _____ Surgery _____
4) Date _____ Surgery _____

Do you have any of the following symptoms?

General fatigue weakness fever loss of sleep chills (continuous) weight change night sweats
Headaches dizziness fainting convulsions nervousness
Anxiety depression (prolonged) phobias memory loss/impairment mood swings
Hearing trouble ringing in ears ear pain ear discharge vision trouble pain in eyes eye discharge
Nose/sinus pain excessive drainage nose bleeds (chronic) nasal infections (chronic) absence of smell
Mouth sores bleeding gums enlarged glands absence of taste abnormal taste sensations
tonsillitis/infected tonsils difficulty swallowing
Heat/cold intolerance sugar in urine goiter tremors
Skin rash redness of skin skin itching skin dryness eczema hair changes nail changes
bruise easily
Cough (chronic) wheezing (chronic) difficulty breathing swollen extremities blue extremities
varicose veins rapid heartbeat chest pain heart palpitations heart murmur
Decreased appetite increased appetite abdominal pain hemorrhoids excessive gas
Excessive vomiting excessive diarrhea constipation heartburn/indigestion diabetes
Prostate problems painful urination inability to hold urine frequent urination bed-wetting
irregular menstruation painful menstruation abnormal vaginal bleeding sterility
Impotence lumps in breast(s) redness/itching in breast dimpling of breast(s) discharge in breast(s)
breast pain

Signature: _____ ***Date:*** _____

And finally, welcome to our office! We look forward to serving you and providing you with the highest quality of chiropractic care.