Neises
Chiropractic Clinic

Patient Symptom Record

Major Complaint:	How long has it existed?
How did it occur?	How would you describe it? (Please circle one) Brief Periodic Constant
What makes the pain worse?	What makes the pain better?

Rate your pain:	0 = No pain					10 = Extremely Intense					Please circle your responses
Right Now	0	1	2	3	4	5	6	7	8	9	10
At its worst	0	1	2	3	4	5	6	7	8	9	10
At its best	0	1	2	3	4	5	6	7	8	9	10

Please use the symbols on the left to mark the areas on your body of your main complaint.
If headaches are your main complaint, please mark the facial drawings on the reverse side.

B = Burning

D = Dull Pain

H = Throbbing

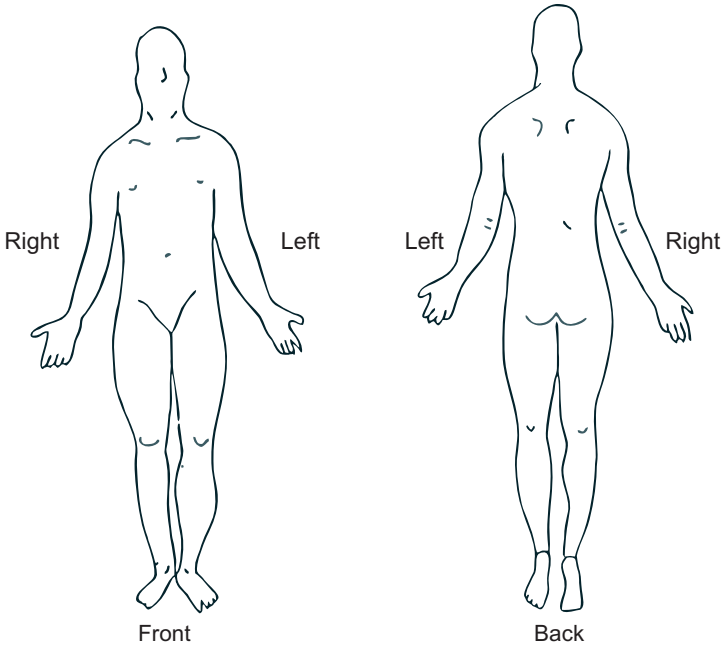
N = Numbness

P = Pressure

R = Radiating/Shooting

S = Sharp/Shooting

T = Tingling



Signature _____ Date _____

Patient Name _____ Date _____

IMPORTANT: Please check ✔ all present symptoms

GENERAL

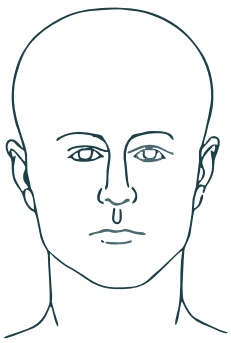
__ Nervousness
__ Irritable
__ Depressed
__ Fatigued
__ Generally feel run down
__ Loss of sleep
__ Weight loss ___ lbs.
__ Weight gain ___ lbs.
__ Coffee/tea consumption ___ cups per day
__ Cigarettes ___ packs per day
__ Alcohol consumption ___ drinks per week
__ Diabetes
__ Hypoglycemia
__ Other _____

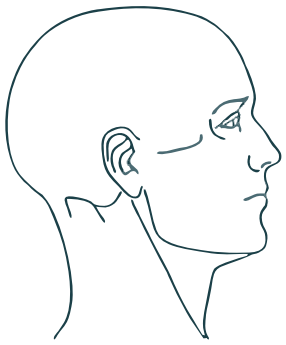
Remarks

	Type	Year
List any accidents or falls:		
List all surgeries:		
List all fractures or broken bones:		
Medications you are presently taking (prescribed or non-prescribed):		
Have you had previous chiropractic care? If so, please list doctor or clinic name:		
Name of primary physician/MD:		

Headaches: With your headaches, do you have any of the following symptons?

____ Loss of taste/smell
____ Loss of hearing
____ Loss of consciousness/fainting
____ Loss of balance
____ Visual disturbances
____ Light sensitivity
____ Ringing.buzzing in the ears
____ Dizziness
____ Confusion/poor memory
____ Vomiting/nausea
____ Congestion/sinus problems
____ Waking at night
____ Head feels heavy





Are you or do you think you may be pregnant? ☐ Yes ☐ No