SPINOS FAMILY CHIROPRACTIC

NAME_____ DATE_____

It is getting: ❑ Improving ❑ Staying the same ❑ Getting Worse
Have you lost time from work? ❑ Yes ❑ No
Can you perform physical work activities? ❑ Yes ❑ No

Please circle all activities which you are currently experiencing problems:

Seeing	Tasting	Smelling	Eating
Hearing	Bathing	Grooming	Dressing
Reading	Typing	Writing	Grasping
Holding	Pinching	Standing	Leaning
Walking	Stooping	Squatting	Climbing
Kneeling	Bending	Twisting	Carrying
Lifting	Pushing	Pulling	Reaching
Sitting	Driving	Riding in car	Air Travel
Sports	Exercising	Loss of sexual drive	Irritable
Reclining	Restful sleeping	Nervous	
Insomnia	Using the toilet		
Loss of concentration			

Complaint area: (Circle One) Neck Mid-Back Low Back Other

This complaint came on: ❑ Gradually ❑ Immediately

The intensity of this complaint is: ❑ Minimal ❑ Slight ❑ Moderate ❑ Severe

The frequency of this complaint is: ❑ Intermittent ❑ Occasional ❑ Frequent ❑ Constant

The pain is: ❑ Dull ❑ Sharp ❑ Aching ❑ Shooting ❑ Spasm ❑ Throbbing ❑ Burning

❑ Numbing ❑ Tingling ❑ Other _____

The pain is located on:	❑ Left Side	❑ Right Side	❑ Both Sides

Actions affecting this complaint:

Morning	❑ Brings On	❑ Aggravates	❑ Relieves
Bending Back	❑ Brings On	❑ Aggravates	❑ Relieves
Twisting Left	❑ Brings On	❑ Aggravates	❑ Relieves
Sneezing	❑ Brings On	❑ Aggravates	❑ Relieves
Lifting	❑ Brings On	❑ Aggravates	❑ Relieves
Cold	❑ Brings On	❑ Aggravates	❑ Relieves
Medication	❑ Brings On	❑ Aggravates	❑ Relieves
Afternoon	❑ Brings On	❑ Aggravates	❑ Relieves
Bending Left	❑ Brings On	❑ Aggravates	❑ Relieves
Twisting Right	❑ Brings On	❑ Aggravates	❑ Relieves
Straining	❑ Brings On	❑ Aggravates	❑ Relieves
Sitting	❑ Brings On	❑ Aggravates	❑ Relieves
Resting	❑ Brings On	❑ Aggravates	❑ Relieves
Bending Forward	❑ Brings On	❑ Aggravates	❑ Relieves
Bending Right	❑ Brings On	❑ Aggravates	❑ Relieves
Coughing	❑ Brings On	❑ Aggravates	❑ Relieves
Standing	❑ Brings On	❑ Aggravates	❑ Relieves
Heat	❑ Brings On	❑ Aggravates	❑ Relieves
Lying Down	❑ Brings On	❑ Aggravates	❑ Relieves

Can you go to sleep without problems?	❑ Yes	❑ No
Do you awaken because of pain?	❑ Yes	❑ No
Did you have sleep problems before?	❑ Yes	❑ No