Optimal Wellness Chiropractic Center

Description of Symptoms

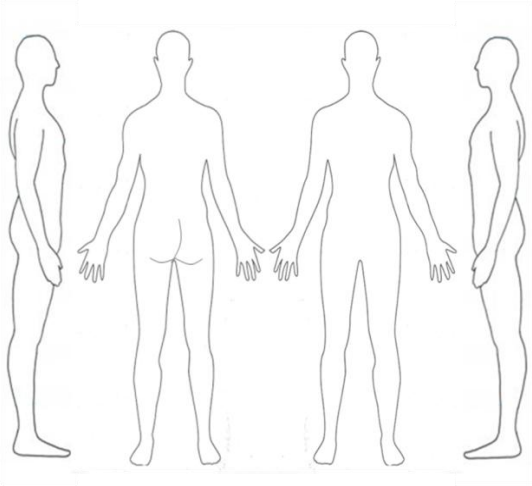
Describe only your **WORST** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

A) FIRST Current Symptoms: (Please check off the boxes in the sections below to describe your one WORST symptom)

1) Check only ONE body location below

Choose One:	Left	Right	Both
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐
☐ Headaches	☐	☐	☐
☐ Front ☐ Top ☐ Back of head			
☐ Other locations: _____			

Indicate on the drawing below the location of your WORST complaint only



2) Types of pain

☐ Dull	☐ Sharp	☐ Aching	☐ Cutting
☐ Throbbing	☐ Burning	☐ Numbing	☐ Tingling
☐ Spasm	☐ Stinging	☐ Shooting	☐ Pounding
☐ Cramping	☐ Constricting		

Other types of pain: _____

3) Pain Frequency

☐ Up to ¼ of awake time	☐ ¼ to ½ of time
☐ ½ to ¾ of awake time	☐ Most all the time

4) **Pain Intensity** *(How it affects daily activities)*

☐ Doesn't affect	☐ Somewhat affects
☐ Seriously affects	☐ Prevents activities

5) Does this pain radiate other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation: _____

6) Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

Description of Symptoms

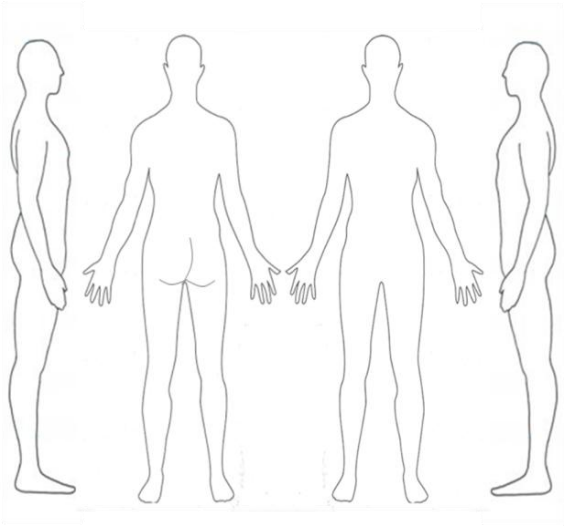
Describe only your **SECOND** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

B) SECOND Current Symptoms: (Please check off the boxes in the sections below to describe your one SECOND symptom)

1) Check only ONE body location below

Choose One:	Left	Right	Both
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐
☐ Headaches	☐	☐	☐
☐ Front ☐ Top ☐ Back of head			
☐ Other locations: _____			

Indicate on the drawing below the location of your SECOND complaint only



2) Types of pain

☐ Dull	☐ Sharp	☐ Aching	☐ Cutting
☐ Throbbing	☐ Burning	☐ Numbing	☐ Tingling
☐ Spasm	☐ Stinging	☐ Shooting	☐ Pounding
☐ Cramping	☐ Constricting		

Other types of pain: _____

3) Pain Frequency

☐ Up to ¼ of awake time	☐ ¼ to ½ of time
☐ ½ to ¾ of awake time	☐ Most all the time

4) **Pain Intensity** *(How it affects daily activities)*

☐ Doesn't affect	☐ Somewhat affects
☐ Seriously affects	☐ Prevents activities

5) Does this pain radiate other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation: _____

6) Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

Description of Symptoms

Describe only your **THIRD** symptom, or chief complaint, on this page. Additional complaints can be entered on the following pages.

C) THIRD Current Symptoms: (Please check off the boxes in the sections below to describe your one THIRD symptom)

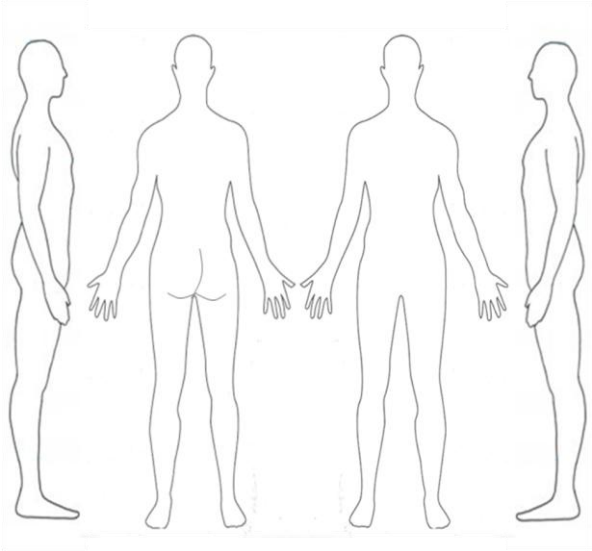
6) Check only ONE body location below

Choose One:	Left	Right	Both
☐ Jaw	☐	☐	☐
☐ Eye	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Upper Back	☐	☐	☐
☐ Mid Back	☐	☐	☐
☐ Low Back	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Abdomen	☐	☐	☐
☐ Ribs	☐	☐	☐
☐ Buttocks	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Upper Arm	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐
☐ Headaches	☐	☐	☐

☐ Front ☐ Top ☐ Back

☐ Other locations: _____

Indicate on the drawing below the location of your THIRD complaint only



7) Types of pain

☐ Dull	☐ Sharp	☐ Aching	☐ Cutting
☐ Throbbing	☐ Burning	☐ Numbing	☐ Tingling
☐ Spasm	☐ Stinging	☐ Shooting	☐ Pounding
☐ Cramping	☐ Constricting		

Other types of pain: _____

8) Pain Frequency

☐ Up to ¼ of awake time	☐ ¼ to ½ of time
☐ ½ to ¾ of awake time	☐ Most all the time

9) **Pain Intensity** *(How it affects daily activities)*

☐ Doesn't affect	☐ Somewhat affects
☐ Seriously affects	☐ Prevents activities

10) Does this pain radiate other body parts?

	Left	Right	Both
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Shoulder	☐	☐	☐
☐ Arm	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Hip	☐	☐	☐
☐ Leg	☐	☐	☐
☐ Foot	☐	☐	☐

Other locations of radiation: _____

6) Actions affecting this pain

	Brings On	Aggravates	Relieves
☐ In the A.M.	☐	☐	☐
☐ In the P.M.	☐	☐	☐
☐ Bending forward	☐	☐	☐
☐ Bending back	☐	☐	☐
☐ Bending left	☐	☐	☐
☐ Bending right	☐	☐	☐
☐ Twisting left	☐	☐	☐
☐ Twisting right	☐	☐	☐
☐ Coughing	☐	☐	☐
☐ Sneezing	☐	☐	☐
☐ Straining	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

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