Petry
CHIROPRACTIC & WELLNESS

COMPLAINT FORM

Date: ___/___/_____

Name _____ Sex: M F Age: _____

List and date **ANY** surgeries: _____

List and date **ANY** accidents or serious injuries: _____

List and date **ANY** broken bones or dislocations: _____

List and date **ANY** diagnosed diseases: _____

Family Physician _____ Phone # (_____) _____ - _____

Date of last physical exam _____ By whom? _____

Have you ever had: (please circle all that apply) spinal xrays MRI or CAT scan

When? _____ Where: _____

CURRENT COMPLAINTS / SYMPTOMS:

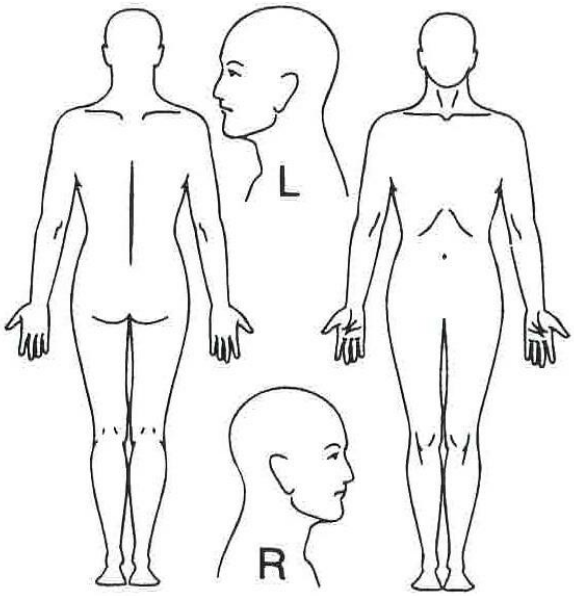
When did you first notice the problem? _____

What do you think caused the problem? _____

Describe the problem (Be as specific as possible):_____

_____

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.



Numbness	**xxxxxxxx**	The Problem:	
Pins & Needles	**……..**	Comes and goes	Is constant
Burning	**oooooooo**		
Aching	**vvvvvvvv**	The problem came on:	
Stabbing	**lllllllllllllll**	Gradually	Suddenly

PAIN LEVEL: On a scale of 1-10, with 0 being you're pain free and can function quite well, and 10 being you're in very severe pain and cannot function at all, where would you rate yourself? (Place an X on the line.)

0 1 2 3 4 5 6 7 8 9 10

NO PAIN **VERY SEVERE PAIN**

What activities, positions, or movements make the problem **worse**? _____

What activities, positions, or movements make the problem **better**? _____

Have you ever had this problem before: ☐ YES ☐ NO If YES, when? _____

Have you ever had chiropractic care before? ☐ YES ☐ NO If YES, from whom? _____

For what problems: _____ For how long: _____

Have you ever consulted a medical physician for this problem? ☐ Yes ☐ No If Yes, whom? _____

When? _____ Length of care: _____ Diagnosis: _____ Treatment: _____

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	**Dosage and Frequency (ie. 5 mg once a day, etc)**

Do you have any medication allergies?			
Medication Name	**Reaction**	**Onset Date**	**Additional Comments**

Family Medical History (Record one diagnosis in your family history and the affected)				
Diagnosis (Write in below)	**Father** **Alive: ☐YES ☐NO**	**Mother** **Alive: ☐YES ☐NO**	**Sibling: How many: _____**	**Offspring: How many: _____**
Example: heart disease				

INDICATE HABITS: ☐ Smoking, _____pks/day ☐ Alcohol, _____ drinks/day ☐ Coffee, _____ cups/day

AMOUNT OF REGULAR EXERCISE PER WEEK: ☐ None ☐ 1 hour ☐ 3 hours ☐ 5 hours ☐ 7 hours or more

AMOUNT OF WATER PER DAY: _____

CIRCLE ALL SYMPTOMS YOU CURRENTLY HAVE AND UNDERLINE ANY YOU HAVE HAD

GENERAL SYMPTOMS
Headaches
Fevers
Chills
Night sweats
Fainting
Dizziness
Convulsions
Fatigue
Nervousness
Loss of weight
Allergies
Hernia
Weakness
Twitching
Swollen joints
Tremors

GASTRO-INTESTINAL
Poor appetite
Excessive hunger
Belching or gas
Nausea
Vomiting
Pain over stomach
Constipation
Diarrhea
Hemorrhoids

SKIN
Itching
Bruise easily
Eczema

CARDIOVASCULAR
Rapid heart rate
Slow heart rate
High blood pressure
Low blood pressure
Pain over heart
Heart trouble
Swelling of ankles
Poor circulation

RESPIRATION
Chronic cough
Spitting blood
Chest pain
Difficulty breathing

EYE EAR NOSE THROAT
Poor vision
Crossed eyes
Poor hearing
Earache / Infection
Ringing in ears
Nose bleeds
Sore throat / hoarseness
Asthma

GENITO-URINARY
Frequent / painful urination
Blood in urine
Inability to control urination
Prostate trouble
Male/Female reproduction

Please list **ANY** other health problems or symptoms not covered: _____

_____

_____