HEALTH CHOICE CHIROPRACTIC CENTER, LLC
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PRESENT COMPLAINTS (PLEASE CHECK THOSE THAT APPLY TO YOU)

- ☐ HEADACHE
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ DIZZY
- ☐ NECK PAIN
- ☐ FAINTING
- ☐ UPPER BACK PAIN
- ☐ LOWER BACK PAIN
- ☐ NECK RESTRICTION
- ☐ NERVOUSNESS
- ☐ FEET/HANDS COLD
- ☐ DEPRESSION
- ☐ TENSION
- ☐ RIB PAIN
- ☐ NECK STIFFNESS
- ☐ SHORTNESS OF BREATH
- ☐ UPPER BACK STIFFNESS
- ☐ LOWER BACK STIFFNESS
- ☐ EYE STRAIN/PAIN
- ☐ FEAR
- ☐ HEAD SEEMS HEAVY
- ☐ CONFUSION
- ☐ CONSTIPATION
- ☐ UNBALANCED
- ☐ CHEST PAIN
- ☐ EARS RINGING/BUZZING
- ☐ MIDBACK PAIN
- ☐ BLURRED VISION
- ☐ LOSS OF TASTE
- ☐ IRRITABILITY
- ☐ PINS/NEEDLES ARMS – R /L
- ☐ PINS/NEEDLES HANDS – R/L
- ☐ PINS/NEEDLES LEGS – R/L
- ☐ MIDBACK STIFF
- ☐ DOUBLE VISION
- ☐ LOSS OF SMELL

DIFFICULTY IN: ☐ STANDING ☐ SITTING ☐ BENDING ☐ WALKING

PAIN RADIATION INTO THE : ☐ RIGHT ARM ☐ LEFT ARM ☐ RIGHT LEG ☐ LEFT LEG

CANNOT LIFT: ☐ LIGHT ☐ MODERATE ☐ HEAVY ☐ REPETITIVE

PAIN IN: ☐ FOOT ☐ ANKLE ☐ KNEE ☐ HIP ☐ HEEL SPURS

OTHER:______________________________

SINCE THE TIME THESE COMPLAINTS BEGAN, WHAT IF ANYTHING HAVE YOU TRIED THAT **DID NOT** WORK?__________

HAS THE PROBLEM INTERRUPTED YOUR SLEEP? ☐ YES - HOW ____________________ ☐ NO

LIST ANY DOCTORS OR THERAPISTS THAT YOU HAVE SEEN FOR THIS COMPLAINT:

1. ____________________ SPECIALTY__________
2. ____________________ SPECIALTY__________
3. ____________________ SPECIALTY__________

RELEVENT MEDICAL HISTORY: (PLEASE CHECK CONDITIONS YOU **HAVE CURRENTLY** OR **HAD PREVIOUSLY**)

ARTHRITIS	EPILEPSY	MUSCULAR DYSTROPHY
ASTHMA	FIBROMYALGIA	NECK PAIN OR SPASMS
ANEMIA	HAND OR WRIST PAIN	NEURITIS
BACK PAIN OR SPASMS	HEADACHES	NUMBNESS
CANCER	HEART PROBLEMS	POLIO
CONCUSSION	HEPATITIS	RHEUMATIC FEVER
CONVULSIONS	HIGH BLOOD PRESSURE	SINUS TROUBLE
DIABETES	HIV	SCIATICA
DIGESTION PROBLEMS	MEASLES	TB
DIZZINESS	MULTIPLE SCLEROSIS	VENEREAL DISEASE

PATIENT NAME_________________________ DATE____________