

**Luedtke-Storm-Mackey Chiropractic Clinic**

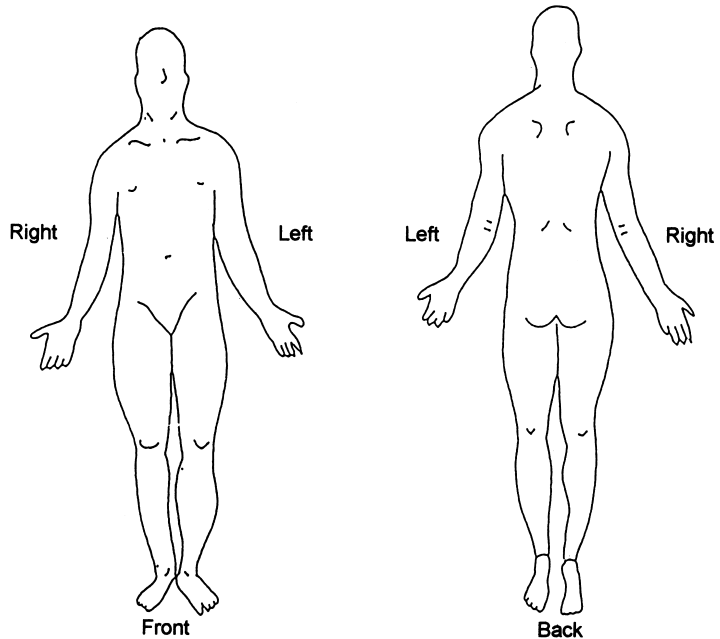
*Patient  
Symptom  
Record*

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 <u>worse</u> ?	What makes the pain <u>better</u> ?

Rate your pain:	0 = No pain										10 = Extremely intense	<i>Please circle your responses</i>
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**

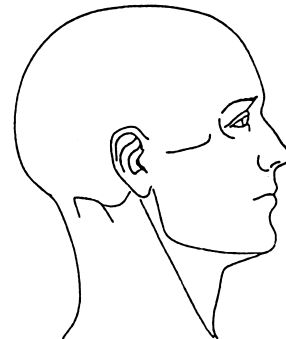
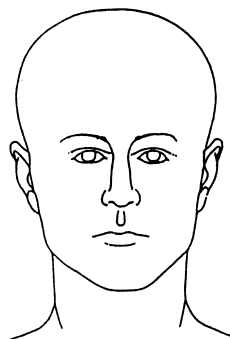
- Nervousness
- Irritable
- Depressed
- Fatigued
- Generally feel run down
- Loss of sleep
- Weight loss \_\_\_\_\_ lbs.
- Weight gain \_\_\_\_\_ lbs.
- Coffee/tea consumption \_\_\_\_\_ cups per day
- Cigarettes \_\_\_\_\_ packs per day
- Alcohol consumption \_\_\_\_\_ drinks per week
- Diabetes
- Hypoglycemia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

Remarks
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	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 symptoms?

- Loss of taste/smell
- Loss of hearing
- Loss of consciousness/fainting
- Loss of balance
- Visual disturbances
- Light sensitivity
- Ringing/buzzing in 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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