LSM Chiropractic Clinic-Patient Symptom Record

The following information is required by Federal Law for us to comply with Electronic Health Records requirements.

Preferred Language: English Other:_____

Height: _____ Weight: _____

Race: Caucasian Hispanic/Latino Other_____

1) Major complaint:	2) How long has it existed?

3) How did it occur?	4) Onset? Gradual Sudden	5) Frequency? Infrequent Periodic Frequent Constant

6) What makes the pain worse?	7) What relieves the pain?

8) Pain Level:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

9 & 10) **Please use the symbols on the left to mark the areas of your main complaint**

B = Burning

D = Dull

H = Throbbing

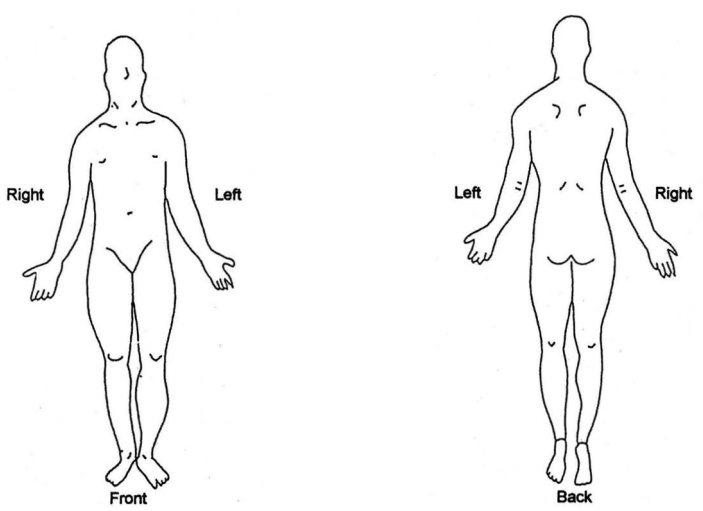
N = Numbness

P = Pressure

R = Radiating/Shooting

S = Sharp/Shooting

T = Tingling



Activities of Daily Living: Please indicate which activities you **currently have difficulty performing** as a result of your condition

☐ Lying on Back	☐ Cough/Sneeze	☐ Walking	☐ Standing	☐ Get in or out of car
☐ Lying on sides	☐ Bending	☐ Kneeling	☐ Getting dressed	☐ Sitting
☐ Lying on stomach	☐ Reaching	☐ Lifting	☐ Twist/Turn Right	☐ Using Computer
☐ Turning over in Bed	☐ Push/Pull	☐ Using Stairs	☐ Twist/Turn Left	☐ Transition from sitting

For This Episode:

11) List prior treaments/Professional Care:_____

12) List any Medications taken:

FOR WOMEN ONLY Are you or do you think you may be pregnant? ☐ No ☐ Yes If YES, due date_____

_____ _____

Patient Signature Date

13) **Family History (Please check all that apply)**	Mother	Father	Siblings	Grandparents	Notes
Arthritis (including Rheumatoid)					
Scoliosis					
Multiple Sclerosis					
Diabetes					
Heart Disease & Stroke					
Cancer					
Other:					

14) Past Medical History

Name of Primary Care Physician/MD:_____

Have you had previous Chiropractic care? □ No □ Yes – Doctor/Clinic Name: _____

Describe any previous Hospitalizations, Infections, Traumas (accident/injury) or Surgeries:

_____

ANY medications that you are presently taking (prescribed/non-prescribed):

Please list any allergies you have to Medicines/Food/Environment/Other:

15) Social History

Occupation: _____ Recreational activities/Hobbies/Sports: _____

Do you exercise? □ No □ Yes – How Often? _____ What Type: _____

Do you use a computer? □ No □ Yes – How many days per week? _____ How many hours per day (average)? _____

Please circle smoking status: Never Smoked Former Smoker Current/Daily Current/Occasional

16) Review of Systems

Constitutional	**Cardiovascular**	**Neurological**
□ Unexplained weight loss	□ Chest pain	□ Tingling
□ Fatigue/malaise/lethargy	□ Heart attack	□ Numbness
□ Fever	□ T.I.A. (mini-stroke)	□ Limb weakness
□ Cancer	□ Stroke	□ Speech problems
Ears, Nose and Throat	**Respiratory**	**Gastrointestinal**
□ Sinus pain	□ Shortness of breath	□ Bloating
□ Ear pain	□ Exercise intolerance	□ Nausea/vomiting
□ Ringing in ears (tinnitus)	□ Asthma	□ Constipation/diarrhea
Genitourinary	**Endocrine**	**Eyes**
□ Frequent urination	□ Diabetes	□ Double vision
□ Nocturia (night urination)	□ Hypothyroid (decreased function)	□ Blurred vision
□ Kidney stones	□ Hyperthyroid (increased function)	□ Scotomas (visual defect)

_____ _____

Patient Signature Date

03/2016

For Clinic Use Only:

BP: _____ Notes: _____

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