Melman Chiropractic Group, PC

Describe Complaints: *Please be specific*

Head & Neck:____

Mid-Back / Shoulders / Arms & Hands:_______________________________________

Low Back / Hips / Legs & Feet:____

Other:____

APPROXIMATE DATE PAIN OR SYMPTOMS BEGAN________________________________

WHAT WERE YOU DOING AT THE TIME?_____________________________________

CHECK PROPER SPACE

Symptoms: ( ) came on suddenly ( ) came on gradually ( ) come and go

Symptoms have persisted for: ( ) hours ( ) days ( ) weeks ( ) months ( ) years

Symptoms are better in: _____ A.M. _____ MIDDAY _____ P.M.

Symptoms are worse in: _____ A.M. _____ MIDDAY _____ P.M.

_____ Symptoms do not change with time of day

WHAT ACTIVITIES MAKE CONDITION WORSE?__________________________________

WHAT ACTIVITIES MAKE CONDITION BETTER?_________________________________

OTHER DOCTORS SEEN FOR THIS CONDITION

1ST DOCTOR/HOSPITAL SEEN WAS: ____ ( ) MD ( ) DC

Date of first visit___________ Were you examined? Yes / No Were x-rays taken? Yes / No
Date of last visit___________

Were you given any treatment including medication? yes / no
If yes, what treatment was given to you? ____

What benefits did you receive from the treatment? ____________________________________

What other tests were performed? ____

HAVE YOU MISSED TIME FROM WORK? YES / NO IF YES:

( ) full time off from work ____________ to _____________ ( ) part time off work from ___________ to __________

Have you been treated by a physician for any other health condition in the last year? ( ) yes ( ) no

IF YES, PLEASE DESCRIBE: ____

WHAT SURGERIES HAVE YOU HAD?

DATE SURGERY

____
____
____