Vitality Life Chiropractic, LLC

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Symptoms History

Name: _____ **Date:** _____

List your primary complaints in order of concern:

1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

Have your complaints limited any of your regular daily activities? Yes No If yes, which activities?
_____
_____

How long have you had the complaint(s)? _____

Are they due to any type of injury? Yes (give date) _____ No

Describe your injury: _____

How often does it bother you? _____

Has your problem been getting better? Worse? Or staying the same? _____

Did your present problem appear slowly? Immediately? After trauma? _____

What aggravates the problem? _____

What makes the problem better? _____

What other treatments have you tried that have been unsuccessful? _____
_____

Have you seen any other healthcare provider for your complaints? Yes No If yes, please list: _____
_____

Have you had *any* previous chiropractic care? Yes No If yes, what for and what were the results? __
_____

Are you taking any medications? Yes No If yes, please list: _____
_____

Are you under any other treatment for this condition? _____
_____

Have you ever been hospitalized? Yes No If yes, for what? _____

List *all* previous surgeries: _____

List *all* previous accidents: _____

List *all* previous broken bones: _____

If your problem was left unhandled for five years, how do you think it would affect you? _____
_____

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Are you committed to getting rid of your symptoms and their cause even if it means a change in lifestyle? Yes No If no, why not? _____

_____

Circle any of the following you have had or currently have:

Headaches
Shooting head pains
Loss of smell
Hay fever
Asthma
Loss of taste
Tightness of throat/Inflammation of throat
Thyroid trouble
Face flushed
Twitching of face
Loss of memory
Fatigue
Dizziness
Fainting
Loss of balance
Ringing in ears
Wear glasses
Lights bother eyes
Muscle spasms in neck
Grating/Grinding in neck or back
Tightness of shoulder muscles
Neuritis in shoulders and arms
Pins and needle in arms and hands
Cold hands
Chest pains
Shortness of breath
T.B.
Heart Pain
Heart palpitation
Heart attacks
High blood pressure
Low blood pressure
Anemia
Rheumatic fever
Nervous stomach
Stomach trouble
Ulcers
Nerves and nervousness
Inner tension
Irritability
Cold sweats
Liver trouble
Gall bladder trouble
Indigestion
Intestinal gas
Constipation
Kidney trouble
Bladder trouble
Menstrual cramps and pain
Diabetes
Cancer
Sleeping problems
Painful joints
Swollen joints
Arthritis
Slipped disc.
Pinched nerves in back
Pins and needles in legs
Swollen ankles
Cold feet
Pains in legs and feet

Have you been ever been diagnosed with or ever tested positive for any of the following (please circle)? HIV/Aids Hepatitis B Hepatitis C

_____
_____
_____
_____
_____
_____
_____
_____
_____