

Vitality Life Chiropractic, LLC

Symptoms History

Name: _____ **DATE:** _____

List your primary complaints in order of concern:

A _____ D _____

B _____ E _____

C _____ F _____

Have your complaints limited any of your regular daily activities? Yes No

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 what for? _____

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? _____

