



THILL CHIROPRACTIC CENTER

1040 BUSSE HIGHWAY SUITE 101 , PARK RIDGE, IL 60068 | PHONE: 847-692-6655

Name: _____
Last First

Please list the main areas of your pain or symptoms _____

Does the pain travel to another area? _____ where is that located _____

On a scale of 1-10, My current pain level is _____ **(mild 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 severe)**

When did you first experience pain? _____ Have you felt this pain before? _____

How often do you experience pain? constantly, daily, once a week, once a month, with activity

What kinds of words describe your pain? achy, stiffness, sharp, shooting, tingly, numbness, pins

Describe any pervious falls, slips, injuries, or motor vehicle accidents within the past five years

General: Have you had any recent weight loss or unexpected fever or fatigue? Y N

Eyes: Have you had any loss of vision, double vision, or change in your eye site? Y N

Heart: Any dizzy spells, irregular heartbeat, shortness of breath, or chest pain? Y N

Respiration: Do you have a persistent cough, wheeze, or coughed up blood? Y N

Do you have any abdominal pain, heart burn, nausea, constipation, diarrhea? Y N

Discomfort while urinating/ getting up at night to urinate several times? Y N

Please rate your current amount of stress? _____ **(mild 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 severe)**

Signature _____ Date _____