THILL
CHIROPRACTIC
CENTER
1040 BUSSE HIGHWAY, SUITE 101, PARK RIDGE, IL 60068| P.847-971-4184

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