Family Chiropractic & Health Center 1515 University Blvd. Tuscaloosa, AL 35401 (205)758-2225

CURRENT COMPLAINT HISTORY

PATIENT'S NAME:____

1. What is your Major Complaint (symptom, or reason for visit)? ____
2. Is this the first time you've ever had this problem? ↓

□**Yes** If yes, when did it start? _________________________

□**No** If no when was the first time you had it? ______________ and how did it occur originally?______________________

3. Is this episode the result of a □**Injury** □**Car Accident** □**Work Injury** □**None of the preceeding**
4. Have your symptoms become worse since they started? ↓

□**Yes** If yes, how: □**more intense** □**more frequent** □**more area involved**

□**No**

5. How frequent are the symptoms → □**Constant (24/7) or**

□**Come & Go**↓

If it **comes & goes** does it bother you daily? □**Yes** □**No** When it bothers you how long does it last? □**Few Hours** or □**Minutes**

6. Describe some things that can make the problem worse. ____

7. Describe things that can relieve the problem (even temporarily): ____

8. Describe the pain: □Sharp □Aching □Burning □Stabbing □Dull □Numbness □Tingling Other: __________

9. Please place an "X" on the line below to indicate the level of Pain (Symptoms)

No Symptoms --Extreme Symptoms

10. Are there any others symptoms you are having that may or may not be related to the above problem? ________________

____

11. Have you had any major illnesses, injuries, falls, auto accidents or surgeries? ____________________________

____

12. Have you been treated for a health condition by a physician in the past year? □**Yes** □**No** If yes, describe _______________

____

13. *For women only.* Are you pregnant or is there a possibility that you are pregnant? □**Yes** □**No**

14. Have you ever been diagnosed as having or have suffered from? (Check below if different than above)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__High/Low Blood Pressure
__Circulatory Problems	__Epilepsy	__Alcoholism	__Coughing Blood
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Ulcers
__Seizures/Convulsions	__Strokes	__HIV Positive	__Excessive Bleeding
__Congenital Disease	__Cancer	__Gall Bladder	__Depression

List any medications you are taking. ____

______________________________________ ____/____/____

Patient's Signature Date