Karminski Chiropractic
Natural Health and Wellness

Today's Date: _____

PATIENT BASIC INFORMATION

Name: First_____ MI _____ Last_____

Date of Injury/Onset:_____ Dominant Hand: Left / Right / Both

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury, or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

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Today's Date: _____

Patient Name:_____

Description of Symptoms: (Describe symptoms below, in the order of severity if possible)

First Current Symptom (Describe only ONE symptom per section)

1. Check on location below

□Headaches □L □R □B
Part of head:
□Front □Top □ Back
□Jaw □L □R □B
□Eye □L □R □B
□Neck □L □R □B
□Upper Back □L □R □B
□Mid Back □L □R □B
□Low Back □L □R □B
□Chest □L □R □B
□Abdomen □L □R □B
□Ribs □L □R □B
□Buttocks □L □R □B
□Shoulder □L □R □B
□Upper Arm □L □R □B
□Forearm □L □R □B
□Hand □L □R □B
□Hip □L □R □B
□Leg □L □R □B
□Foot □L □R □B
□Other Locations:_____
_____

2. Types of Pain:

□Dull □Sharp □Aching □Cutting
□Throbbing □Burning □Numbing □Tingling □Cramping
□Spasm □Stinging □Shooting □Pounding □Constricting
Other:_____

3. Pain Frequency

□¼ of awake time □¼ to ½ time
□½ to ¾ time □Most all the time

4. Pain Intensity: How does it affect your daily activities?

□Doesn't Affect □Somewhat Affects
□Seriously Affects □Prevents Activity

5. Does this pain radiate into other body parts?

Head □L □R □B
Neck □L □R □B
Shoulder □L □R □B
Arm □L □R □B
Hand □L □R □B
Hip □L □R □B
Leg □L □R □B
Foot □L □R □B
Other:_____

6. Actions affecting this pain

Brings On/Aggravates/Relieves

□In the A.M. □ □ □
□In the P.M. □ □ □
□Bend forward □ □ □
□Bend back □ □ □
□Bend left □ □ □
□Bend right □ □ □
□Twist left □ □ □
□Twist right □ □ □
□Coughing □ □ □
□Sneezing □ □ □
□Straining □ □ □
□Standing □ □ □
□Sitting □ □ □
□Lifting □ □ □
Other: _____
_____

Second Current Symptom (Describe only ONE symptom per section)

1. Check on location below

□Headaches □L □R □B
Part of head:
□Front □Top □ Back
□Jaw □L □R □B
□Eye □L □R □B
□Neck □L □R □B
□Upper Back □L □R □B
□Mid Back □L □R □B
□Low Back □L □R □B
□Chest □L □R □B
□Abdomen □L □R □B
□Ribs □L □R □B
□Buttocks □L □R □B
□Shoulder □L □R □B
□Upper Arm □L □R □B
□Forearm □L □R □B
□Hand □L □R □B
□Hip □L □R □B
□Leg □L □R □B
□Foot □L □R □B
□Other Locations:_____
_____

2. Types of Pain:

□Dull □Sharp □Aching □Cutting
□Throbbing □Burning □Numbing □Tingling □Cramping
□Spasm □Stinging □Shooting □Pounding □Constricting
Other:_____

3. Pain Frequency

□¼ of awake time □¼ to ½ time
□½ to ¾ time □Most all the time

4. Pain Intensity: How does it affect your daily activities?

□Doesn't Affect □Somewhat Affects
□Seriously Affects □Prevents Activity

5. Does this pain radiate into other body parts?

Head □L □R □B
Neck □L □R □B
Shoulder □L □R □B
Arm □L □R □B
Hand □L □R □B
Hip □L □R □B
Leg □L □R □B
Foot □L □R □B
Other:_____

6. Actions affecting this pain

Brings On/Aggravates/Relieves

□In the AM □ □ □
□In the PM □ □ □
□Bend forward □ □ □
□Bend back □ □ □
□Bend left □ □ □
□Bend right □ □ □
□Twist left □ □ □
□Twist right □ □ □
□Coughing □ □ □
□Sneezing □ □ □
□Straining □ □ □
□Standing □ □ □
□Sitting □ □ □
□Lifting □ □ □
Other: _____
_____

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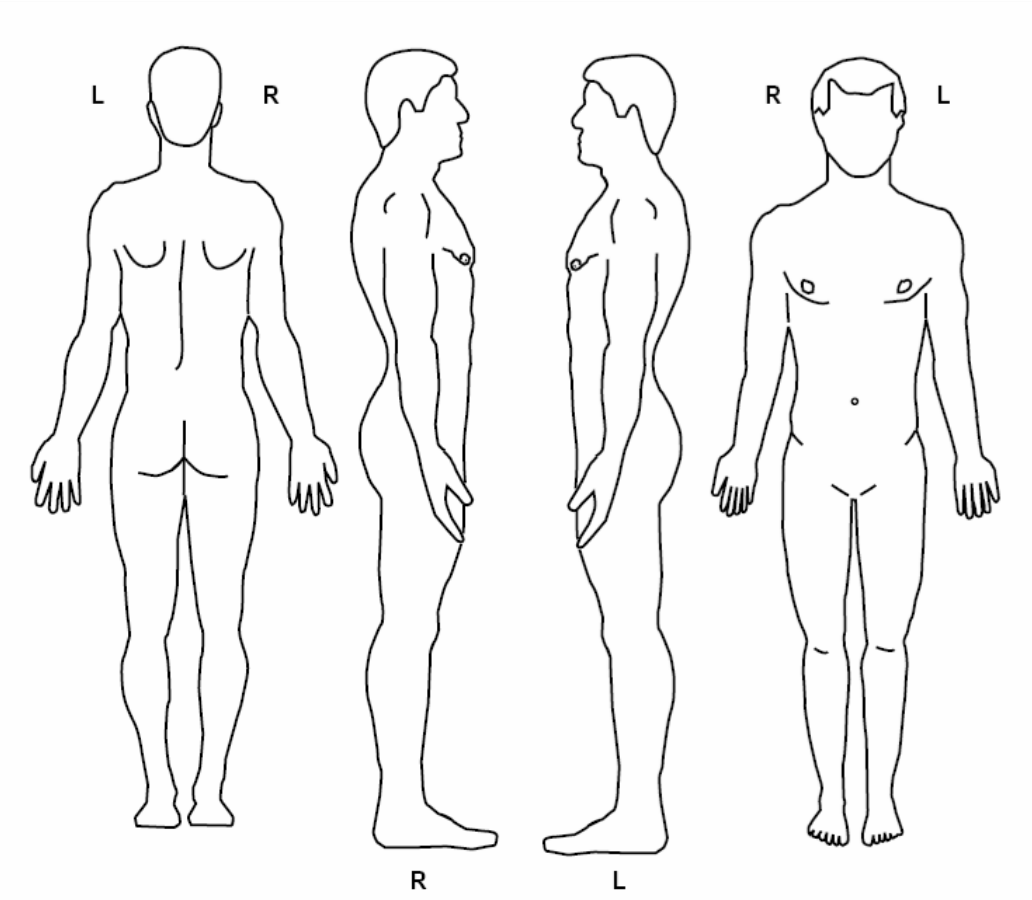
Pain Drawing

Name:_____ Date: _____
Last, First MM/DD/YYYY

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness --------- Pins & Needles ooooo Burning Pain xxxxx Stabbing Pain ///////// Aching Pain (((((((((



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain:

No Pain:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Unbearable Pain**
Right Now:	0	1	2	3	4	5	6	7	8	9	10	_____
Average Pain:	0	1	2	3	4	5	6	7	8	9	10	_____
At Best	0	1	2	3	4	5	6	7	8	9	10	_____
At Worst:	0	1	2	3	4	5	6	7	8	9	10	_____

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Name:_____ Date: _____
Last, First MM/DD/YYYY

Since your last visit to our office have you:

Had any surgeries? If so explain below:

_____

_____

_____

_____

Experienced any major trauma? If so explain below:

_____

_____

_____

_____

Experienced any sickness or illness? If so explain below:

_____

_____

_____

_____

Started or stopped any new medications? If so explain below:

_____

_____

_____

_____