

# Integrative Health & Wellness Lewiston Family Chiropractic

1. When did your problem begin: \_\_\_\_\_ (specific date if possible)

2. Describe your symptoms and how they began: \_\_\_\_\_  
\_\_\_\_\_

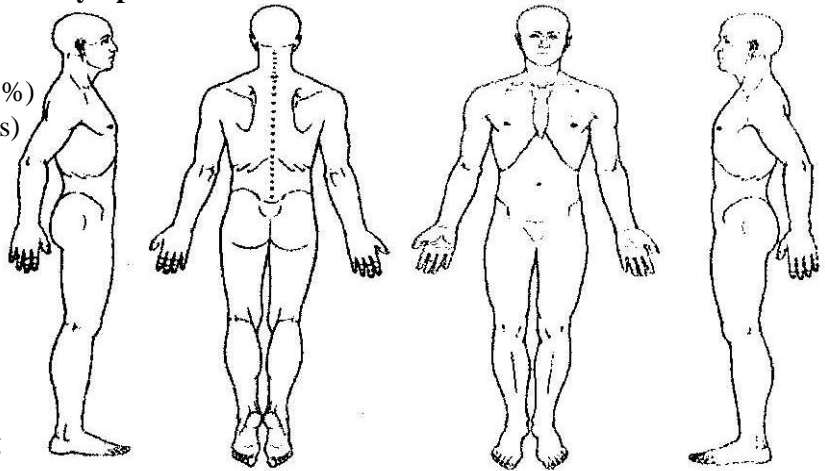
3. Indicate on the body where you have pain or other symptoms:

4. How often are the complaints present:

- Constant (100-76%)       Frequent (75-51%)  
 Occasional (50-26%)     Intermittent (less)

5. Check all that describe your symptoms:

- Numbness     Shooting     Sharp/Dull  
 Aches         Burning      Soreness  
 Weakness     Tingling     Throbbing  
 Gripping/Constricting     Sharp/Stabbing



6. Since your problem began is the pain:

- Increasing     Decreasing     Not Changing

7. How bad are you symptoms at their (circle one) **WORST:** No Pain – 1 2 3 4 5 6 7 8 9 10 – Unbearable  
How bad are your symptoms at their (circle one) **BEST:** No Pain – 1 2 3 4 5 6 7 8 9 10 – Unbearable

8. Are your complaints affecting your ability to work or otherwise be active:

- No effect                       Some restrictions       Need limited assistance with everyday tasks  
 Need assistance often     Significant inability to function without assistance     I Am totally disabled

9. What makes your problem worse:

- Nothing                       Lying Down                       Sitting                       Standing  
 Walking                       Inactivity                       Movement/Exercise                       Other: \_\_\_\_\_

10. What makes your problem better:

- Nothing                       Lying Down                       Sitting                       Standing  
 Walking                       Inactivity                       Movement/Exercise                       Other: \_\_\_\_\_

11. What treatment have you received for this present condition:

- Surgery       Spinal injections       Physical Therapy       Massage Therapy       Pain Clinic  
 Medications:  Over the Counter *or*  Prescription       Other: \_\_\_\_\_

12. Were you previously treated for a different occurrence of this same condition:

- No     Yes    If yes by:     Chiropractor     MD                       Therapy     Massage     Pain Clinic

13. How would you grade your general stress level:

- No Stress                       Minimal Stress                       Moderate Stress                       Greatly Stressed

14. Overall General physical activity:

- No regular exercise program                       Light exercise program                       Strenuous exercise program

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_