Chagrin Valley Chiropractic and Acupuncture Center, LLC

Patient Name_____ **Date**_____

History of Chief Complaint (please be specific as possible):

Reason for visit:
#1_____ #2_____ #3_____

Date of onset:
#1_____ #2_____ #3_____

How did illness(es)/injury(ies) occur_____
_____
_____
_____

Do the symptoms radiate anywhere?(please describe and also use the attached pain diagram)_____
_____

Please rate symptoms on scale of 0-10 (0=no pain/discomfort 10=worst pain/discomfort ever experienced)

#1 Initially:	/10	Currently:	/10	At its worst:	/10	At its best:	/10
#2 Initially:	/10	Currently:	/10	At its worst:	/10	At its best:	/10
#3 Initially:	/10	Currently:	/10	At its worst:	/10	At its best:	/10

What makes symptoms worse_____
_____
_____

What makes symptoms better_____
_____

Do the symptoms get better or worse at any time? (morning, evening, etc)_____
_____

Are the symptoms getting progressively worse or better?_____
_____

Are there any other symptoms that you have noticed since the onset of the chief complaint?_____
_____

Does this complaint interfere with your(check all that apply): ☐Work ☐Recreation ☐Sleep ☐Basic activities of daily living. Please use this area for further description of the above if needed:_____
_____

Have you seen anyone else for this condition? ☐No ☐Yes – If yes describe below
Name of doctor/practitioners_____
Treatment(s) performed_____
Did it help?_____

What are your goals of treatment at this office?_____
_____

_____ _____ _____ _____
Patient Signature **Date** **Dr Signature** **Date**