Integrative Health and
Lewiston Family Chiropractic, LLC

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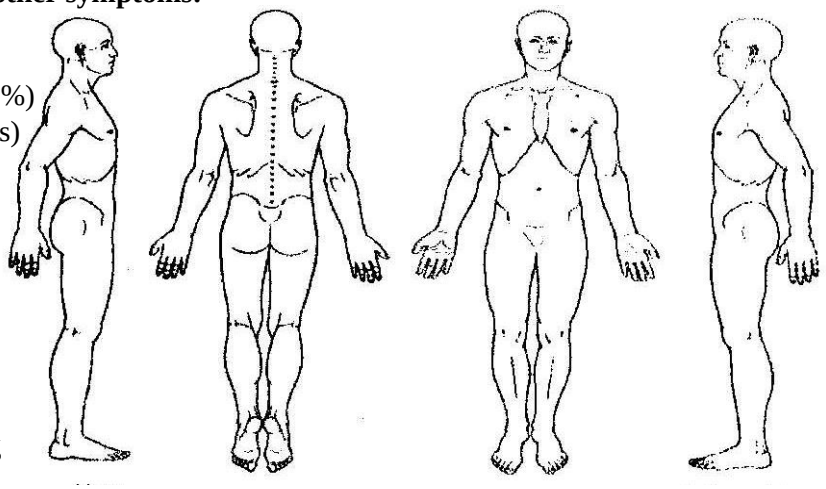
1. **When did your problem begin:** _____ (specific date if possible)

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:** _____