

WHAT BRINGS YOU TO TIGGES CHIROPRACTIC AND WELLNESS? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you have any family members who suffer from the same complaint? If so, who? _____

What is the name of your personal family doctor? _____

Have you been to another doctor for this problem? yes no Who/Where? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate

Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you have any family members who suffer from the same complaint? If so, who? _____

Do you smoke? yes no If yes, how many packs per week? _____

Have you ever smoked in the past? yes no If yes, when did you quit? _____

Do you take birth control? yes no Have you ever taken birth control in the past? yes no

Are you currently pregnant? yes no

Do you consume alcohol? yes no If yes, how many drinks per week? _____

Do you consume caffeine? yes no If yes, how many drinks per day? _____

Do you exercise? yes no If yes, how many times per week and what type? _____

Do you have a high stress level? yes no If yes, list reasons: _____

FAMILY HISTORY

	Mom	Dad	Sibling
Diabetes			
Cancer			
Heart			
Lung			
Thyroid			

Allergies to medications: _____

Patient Signature

Date