Arctic Chiropractic Juneau Patient Name: ______________________________ Date: ____________

SYMPTOM HISTORY FORM

Symptom 1 (please describe)**:** ____

- On a scale from 0-10, with 10 as the worst, circle the number that best describes the symptom most of the time:

0	1	2	3	4	5	6	7	8	9	10

- Circle what percentage of the time you are awake do you experience the above symptom at the above intensity:

5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100

- Did the symptom begin **suddenly** or **gradually**? (circle one)
- When did the symptom begin?____
- How did the symptom begin?____
- Since the symptom began, has it been **getting better**, **getting worse**, or **staying the same**? (circle one)
- What makes the symptom worse? (circle all that apply):

Nothing	All movement	Looking downward	Looking upward
Turning head	Bending forward at waist	Bending backward at waist	Turning at the waist
Jumping/impact	Taking the stairs	Reaching overhead	Reaching behind the back
Chewing	Prolonged positions	Lifting	Driving
Standing	Walking	Running	Exercising
Working	Sitting	Getting up from seated position	Lying on side in bed
Gripping	Squatting	Other (please specify)______________________________	

- What makes the symptom better? (circle all that apply):

Nothing	Resting	Ice	Heat	Stretching	Exercise
Walking	NSAIDs	Muscle relaxers	Massage	Chiropractic adjustments	
Other (please describe): ____					

- Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning	Stiff	Stinging	Nagging	Deep	Stabbing	Throbbing	Piercing
Other (please describe)____										

- Does the symptom radiate to another part of your body (circle one): YES or NO
  - If yes, where does the symptom radiate? ____________________
- Is the symptom worse at certain times of the day or night? (circle all that apply)

Morning	Midday	Afternoon	Evening	Night	No specific time is worse than others

- What providers have you seen for this condition and episode prior to today's visit? (circle all that apply)

MD/DO	Chiropractor	Physical Therapist
Orthopedist	Neurologist	Massage Therapist
ER/Urgent Care	Acupuncturist	Naturopath
Other (specify)__________________________		None

- What treatments for this condition and episode have you had prior to today's visit? (circle all that apply)

Cortisone injections		Surgery	Massage therapy
Trigger point injections		Acupuncture	Physical Therapy
Chiropractic	X-Ray	MRI	CT scan
Medication (specify)_________________________			
Other (specify)______________________________			None

Reviewed by doctor: _______

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Arctic Chiropractic Juneau Patient Name: _________________________________ Date: ____________

SYMPTOM HISTORY FORM

Symptom 2 (please describe)**:** ____

- On a scale from 0-10, with 10 as the worst, circle the number that best describes the symptom most of the time:

0	1	2	3	4	5	6	7	8	9	10

- Circle what percentage of the time you are awake do you experience the above symptom at the above intensity:

5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100

- Did the symptom begin **suddenly** or **gradually**? (circle one)
- When did the symptom begin?____
- How did the symptom begin?____
- Since the symptom began, has it been **getting better**, **getting worse**, or **staying the same**? (circle one)
- What makes the symptom worse? (circle all that apply):

Nothing	All movement	Looking downward	Looking upward
Turning head	Bending forward at waist	Bending backward at waist	Turning at the waist
Jumping/impact	Taking the stairs	Reaching overhead	Reaching behind the back
Chewing	Prolonged positions	Lifting	Driving
Standing	Walking	Running	Exercising
Working	Sitting	Getting up from seated position	Lying on side in bed
Gripping	Squatting	Other (please specify)__________________________________	

- What makes the symptom better? (circle all that apply):

Nothing	Resting	Ice	Heat	Stretching	Exercise
Walking	NSAIDs	Muscle relaxers	Massage	Chiropractic adjustments	
Other (please describe): ____					

- Describe the quality of the symptom (circle all that apply):

Sharp	Dull	Achy	Burning	Stiff	Stinging	Nagging	Deep	Stabbing	Throbbing	Piercing
Other (please describe)____										

- Does the symptom radiate to another part of your body (circle one): YES or NO
  - If yes, where does the symptom radiate? ____________________
- Is the symptom worse at certain times of the day or night? (circle all that apply)

Morning	Midday	Afternoon	Evening	Night	No specific time is worse than others

- What providers have you seen for this condition and episode prior to today's visit? (circle all that apply)

MD/DO	Chiropractor	Physical Therapist
Orthopedist	Neurologist	Massage Therapist
ER/Urgent Care	Acupuncturist	Naturopath
Other (specify)___________________________		None

- What treatments for this condition and episode have you had prior to today's visit? (circle all that apply)

Cortisone injections		Surgery	Massage therapy
Trigger point injections		Acupuncture	Physical Therapy
Chiropractic	X-Ray	MRI	CT scan
Medication (specify)__________________________			
Other (specify)_______________________________			None

Reviewed by doctor: ________

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Patient-Specific Functional Scale

Please identify up to five important activities that you **are unable to do or have difficulty doing** as a result of your current symptoms. Write these down in the spaces provided below, then rate your ability to perform the activity in the last week by circling the appropriate number.

Activity 1:____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 2:____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 3:____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 4:____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

Activity 5____

Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue

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