WHICH OF THE FOLLOWING DESCRIBES YOUR PRESENT PROBLEM?

Please fill out as completely as possible so we know how best to help you!

❑ No obvious cause ❑ Sudden onset of pain: ❑Gradual onset ❑ An Illness ❑ An Injury ❑ A motor vehicle collision

❑ A personal injury 3rd party at fault ❑ A work related injury **Enter the date of the injury, illness or onset of pain:** _____

❑ On going Chiropractic care ❑ Wellness Care ❑ Other (describe): _____

In the blanks provided, list any **SYMPTOMS** that you experienced after the onset of pain, injury, or illness:

Then please choose the appropriate 3 levels of pain descriptions.

Example: ___NECK PAIN_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ☑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ☑ Frequent ❑ Constant

Type of Pain: ❑ None ☑ Aching ❑ Burning ❑ Dull ❑ Pulling ☑ Sharp ❑ Shooting ❑ Stabbing ☑ Stinging ❑ Throbbing

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1. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

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2. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

3._____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

4. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

5. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

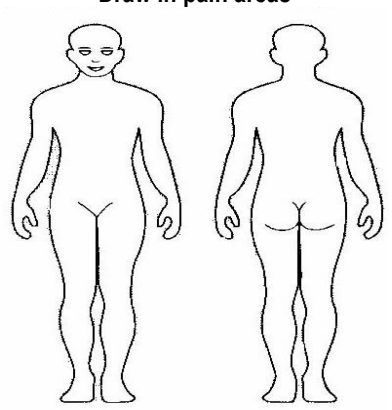
6. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

Print Name: _____

Draw in pain areas



Enter a Full Description of your Complaint, Condition, Accident, or Injury:

(when, where, how, & what hurts) _____

_____

_____

_____

_____

_____

_____

_____

HABITS

❑Smoking Packs/day: _____

❑Alcohol/day): _____

❑CoffeeCups/Day: _____

❑Soda/Day: _____

❑Water Oz/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type Ex: _____

_____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑____
Father	❑	❑	❑	❑____
Brother(s)	❑	❑	❑	❑____
Sister(s)	❑	❑	❑	❑____

List any current medications you take:_____

_____

List any current supplements you take:_____

_____

List any current allergies:_____

_____

List any PAST surgeries? (enter the type and approximate date of surgery):

_____

_____

CIRCLE BELOW ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE NOW, OR HAVE HAD BEFORE:

Alcoholism	Chicken Pox	Measles	Rheumatic Fever
Anemia	Epilepsy	Mental Disorder	Tuberculosis
Appendicitis	Flu	Mumps	Venereal Ds
Cancer	HIV / AIDS	Polio	Whooping Cough

I hereby authorize Dr. Pearce to examine me.

Print Name: _____

Patient's/Guardian's Signature: _____ Date: _____