

Armstrong Chiropractic and Rehabilitation
 8911 W. Maple, Ste. A • Wichita, Kansas 67209 • (316) 721-0011

Patient Name: _____ Date: _____

MEDICAL HISTORY

CHIEF COMPLAINT

What is your major symptom? _____

Please circle your area(s) of discomfort on the figures to the right.

PLEASE DESCRIBE YOUR PAIN OR CONDITIONS

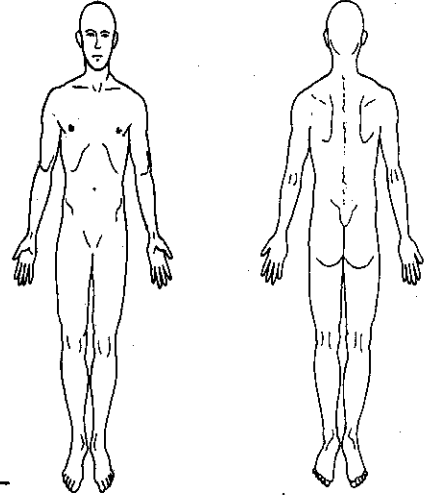
Is your pain: Sharp Dull Numbness Tingling Aching
 Burning Stabbing Other _____

Has your pain: Become worse recently Stayed the same
 Getting better Gradually Worse

How frequent is your condition? Constant Daily Intermittent
 Night only Morning only

How long does it last? All day A few hours Minutes

Are there any other conditions or symptoms that may be related to your major symptom? _____



What makes the problem worse? Standing Sitting Lying Bending
 Lifting Twisting Other _____

What makes the problem better? _____

Does icing help? Yes No Does heat help? Yes No Do you wear a heel lift? Yes No

Does the pain interfere with your sleep? Yes No Does the pain get worse at night? Yes No

Symptoms developed from: Auto Accident Work related injury Other

When did they begin: _____ How did it occur? _____

Does your pain interfere with work or living habits? Yes No If yes, how? _____

HEADACHES	NECK	LOW BACK
Do you experience:	Do you experience:	Do you experience:
Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty turning your head <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/tingling in feet/legs <input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Disturbances <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain or pressure behind eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain down your legs <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain or cracking in jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness of hands/fingers <input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in bowel or bladder function <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you currently suffering from any condition other than that for which you are consulting us? If yes, what? _____

PAST MEDICAL HISTORY

Have you ever seen a chiropractor before? Yes No If yes, what condition? _____

When did you have this condition? _____

Have you previously seen a doctor for the condition you are consulting us? Yes No When? _____

Where treated? _____ By whom? _____

Diagnosis they gave you? _____ Results? _____

Patient or guardian signature: _____ Date: _____

Doctor signature: _____ Date: _____

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM.