DEER VALLEY CHIROPRACTIC
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Phoenix, Arizona 85027
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Name: _____ Date: _____

Reason for today's visit: _____

Date the symptoms began: _____

Are your symptoms due to: □ Auto accident □ Work □ Sports □ Other _____

Explain: _____

Other health care providers seen for these symptoms and when: _____

In what way does this interfere with your normal activities and / or work? _____

_____

When are you most uncomfortable? □ Morning □ Afternoon □ Evening □ During the night □ Other _____

What activities or positions make your symptoms worse?

□ Sitting □ Standing □ Lying Down □ Bending □ Lifting □ Walking □ Other _____

What makes your symptoms feel better? _____

Describe the **quality(s)** of your symptoms: □ Dull □ Sharp □ Throbbing □ Ache □ Burning □ Numbness □ Tingling

How often are your symptoms: □ Occasionally (0 – 25% of the time) □ Intermittently (26 – 50% of the time)

□ Frequently (51 – 75% of the time) □ Constantly (76 –100% of the time)

Please indicate with a "√ " the appropriate box for any of the following symptoms, which you now are experiencing from the accident.

	MUSCULOSKELETAL				**NERVOUS SYSTEM**		
	Headaches				Numbness		
	Neck Pain				Cold /tingling extremities		
	Upper back pain				Paralysis		
	Shoulder pain	L	R		Dizziness		
	Arm pain	L	R		Fainting		
	Arm numbness	L	R		Depression		
	Hand pain	L	R		Forgetfulness		
	Hand numbness	L	R		Fatigue		
	Mid back pain				Stress		
	Chest pain				Loss of Sleep		
	Low back pain				Convulsions		
	Hip pain	L	R		**EYE, EAR, NOSE,THROAT**		
	Sciatic nerve pain	L	R		Vision problems		
	Tailbone pain				Ear infections, ear ache	L	R
	Leg pain	L	R		Hearing loss		
	Leg numbness	L	R		Nose pain / bleeding		
	Knee or foot pain	L	R		Breathing problems		
	Sore muscles				Dental problems		
	Walking Problems				**RESPIRATORY**		
	Fractured Bones				Difficulty breathing		
	Metal screws/implants				Asthma		
	Weak muscles				Chronic cough		
	Stiffness				Chest pain		