

COLLINS CHIROPRACTIC CLINIC

CURRENT COMPLAINTS

Patient's Name: _____

Date: _____

What is the reason for your visit today?

How long have you been experiencing this? _____

Was this the result of an accident or fall? YES NO

If YES, what happened?

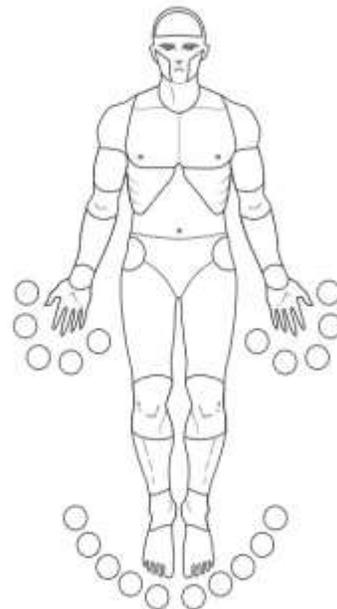
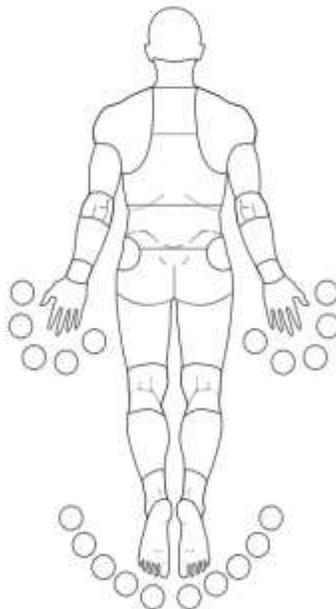
If YES, what was the date of injury? _____

Please circle the number that best describes your current pain. 0 being NO pain and 10 being the most severe pain you have ever experienced.

Pain Scale: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Please indicate the current complaints you are experiencing by circling the areas on the image below and providing details using the Key to the left.

P=Pain
B=Burning
N=Numbness
T=Tingling
A=Aching



Patient's Signature: _____