

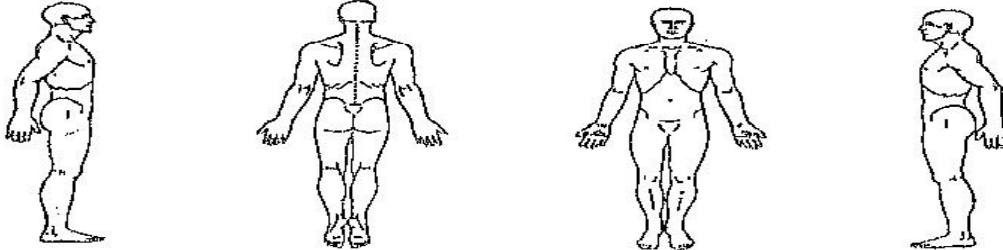
# Symptoms Report Form

Mooney Chiropractic

Patient's Name: \_\_\_\_\_ Account #: \_\_\_\_\_

Describe the location(s) of your current symptom(s): \_\_\_\_\_

Mark the location of your current symptoms (with an "X") on the diagrams below:



Describe the frequency of your symptoms:  Constant (76-100%)  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

Describe the intensity of your current symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Since your symptoms began, are your current symptoms:  Improving  Getting Worse  Not Changing

Please check below the character of your current symptoms (you may mark one or more answers):

sharp  dull  achy  burning  tingling  shooting  weakness  throbbing  numbness  gripping/constricting

Please list the most recent date that your symptoms began or reoccurred: \_\_\_\_/\_\_\_\_/\_\_\_\_

Did your current symptoms occur due to a recent automobile accident? Yes No (If yes, please provide proof of your auto insurance)

Did your current symptoms occur due to a reported work injury or from performing your work duties? Yes No  
(If "yes", please provide our office with Worker's Compensation Insurance Information so we may report your injury as required by law)

Please describe what you think may have caused your symptoms: \_\_\_\_\_

How have your symptoms affected your ability to perform your daily activities at home and at work? \_\_\_\_\_

What have you tried to alleviate these symptoms? \_\_\_\_\_

What makes your problem better?  laying  standing  sitting  walking  movement  inactivity  other: \_\_\_\_\_

What makes your problem worse?  laying  standing  sitting  walking  movement  inactivity  other: \_\_\_\_\_

Have you ever had the same or similar symptoms? Yes No Please describe (including dates, treatment, & results): \_\_\_\_\_

What is your current stress level?  none  minimal  moderate  great Is this usual for you?  yes  no

Please mark your current physical activity at work:  sitting  driving  light manual labor  moderate manual labor  heavy labor

Please mark your current physical daily activity:  no regular exercise  light exercise  moderate exercise  heavy exercise

In order to help you reach your treatment goals, please check the type of care you are seeking for these symptoms.

- First Aid Care (Relieve Pain/Symptoms)
- Corrective Care (Relieve Pain/Symptoms; and Correct Problem causing pain/symptoms)
- Optimal Care (Relieve Pain/Symptoms; Correct Problem; Maintain Good Health; Prevent Future Conditions)

*The best health services are based on a friendly, mutual understanding between provider and patient. Please feel free to discuss your treatment, conditions, and/or concerns with the doctor or staff at any time. We look forward to helping you reach your treatment goals.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_