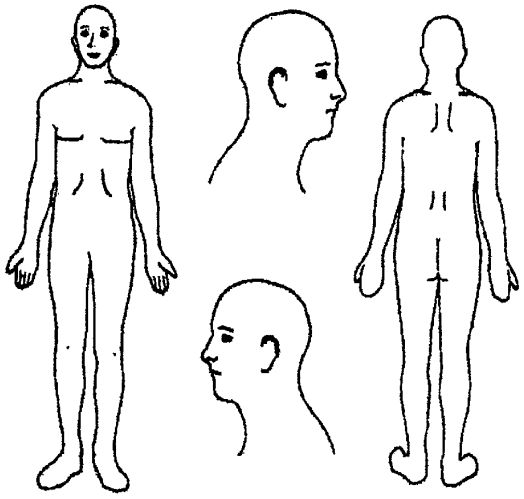
OLIVIERI CHIROPRACTIC HEALTH HISTORY

Name:_____ **Date:** _____

PLEASE SHADE ALL AREAS OF PAIN:



Please check ALL that describe your symptoms:

- ☐ DULL
- ☐ SHARP
- ☐ THROBBING
- ☐ BURNING
- ☐ STABBING
- ☐ TIGHTNESS
- ☐ CRAMPING
- ☐ WEAKNESS
- ☐ PINS & NEEDLES
- ☐ NUMBNESS
- ☐ ACHING

Rate your Pain level from 1-10.

R L Headaches _____
R L Neck Pain _____
R L Radiating into:
Arm, Forearm, Hand _____
R L Upper Back Pain _____
R L Mid Back Pain _____
R L Under Shoulder Blade _____
R L Chest Pain _____
R L Low Back Pain _____
R L Sciatica, radiating into:
Leg, Calf, Foot _____
R L Buttock Pain _____

R L Groin Pain _____
R L Hip Pain _____
R L Thigh Pain _____
R L Knee Pain _____
R L Calf Pain _____
R L Ankle Pain _____
R L Foot Pain _____
R L Shoulder Pain _____
R L Elbow Pain _____
R L Wrist Pain _____
R L Hand Pain _____
R L Dizziness _____

Other: _____

When did your present condition begin? Please provide an approximate date:_____

What happened to cause your present symptoms? _____

_____

What makes your pain better?

☐ Rest ☐ Heating Pad ☐ BioFreeze ☐ Massage ☐ Cervical Pillow ☐ Prescription Medication
☐ Ice Pack ☐ Stretching ☐ Exercise ☐ Back Brace ☐ Changing Positions ☐ Drug Store Medication

What makes your pain worse?

☐ Bending ☐ Lifting ☐ Pulling ☐ Sneezing ☐ Heating Pad ☐ Prolonged Sitting
☐ Twisting ☐ Pushing ☐ Coughing ☐ Sleep ☐ Prolonged Walking ☐ Prolonged Standing

What home remedies have you tried?

☐ Ice Pack ☐ Heating Pad ☐ Exercise ☐ Bed Rest ☐ Massage ☐ Hot Tub ☐ Medication

Are you presently taking any medication? NO YES Please list all:_____
Are you allergic to any medication? NO YES Please list: _____
Have you seen any other doctor(s) for this condition? NO YES Doctor(s):_____
Did the doctor(s) recommend any treatment, or prescribe any medication? NO YES Explain: _____
Have you had any recent testing? NO YES ( ) MRI ( ) X-Rays ( ) CAT Scan ( ) EMG/NCV ( ) Ultrasound
Have you ever had these symptoms before? NO YES Date: _____ Cause:_____Treatment:_____
Have you missed any work from this condition? NO YES Dates: From:_____To: _____**Currently out of work? YES NO**
Do you have a pace maker? NO YES Sudden weight loss or gain in the last 6 months? NO YES
Would you like (circle): pain relief exercise nutritional advise TENS unit posture analysis corrective care

IMPACT OF SYMPTOMS

Please answer each question.

	No Effect	Minimal Effect	Mild Effect	Moderate Effect	Severe Effect
Pain Intensity	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Personal Care	☐	☐	☐	☐	☐
Travel	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	☐
Pain Frequency	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐

*FOR STAFF USE ONLY
Height: _____ Weight: _____ BPL: _____ BPR: _____ PR: _____ Smoke? X C N

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X C N