

# Menner Chiropractic, L.L.C. Patient Condition Report

PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

## SECTION 1

Please complete all 10 questions below

1. Primary complaint: \_\_\_\_\_
2. Is this injury due to:  Work Injury  Auto Injury  Other \_\_\_\_\_
3. When did this begin? \_\_\_\_\_ Has it become:  Better  Worse  Same  
(DATE)
4. What caused this problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Symptoms are worse (check all that apply):  Morning  Afternoon  Evening
6. The pain is:  Intermittent (1-25% of the time)  
 Occasionally (25-50% of the time)  
 Frequent (50-75% of the time)  
 Constant (76-100% of the time)
7. What activities make this condition feel worse?  
 Sleeping  Walking  Sitting  Standing  Bending  
 Sports  Lifting  Push/Pull  Running  Coughing  
 Running  Driving/Riding  Change in Body Position  Sneezing  
 Other \_\_\_\_\_
8. What have you done to relieve this condition?  
 Rest  Sitting  Standing  Hot Pack  Exercise  
 Ice  Stretching  Lying Down  Other \_\_\_\_\_  
 Medications/Drugs Please list Medication(s) \_\_\_\_\_
9. Please rate your pain on a scale from 0 to 10 (Please choose one number)  

0	1	2	3	4	5	6	7	8	9	10	
No Pain											Extreme Pain
10. Have you seen any other doctor(s) for this condition?  No  Yes  
Please list doctor(s) \_\_\_\_\_  
\_\_\_\_\_

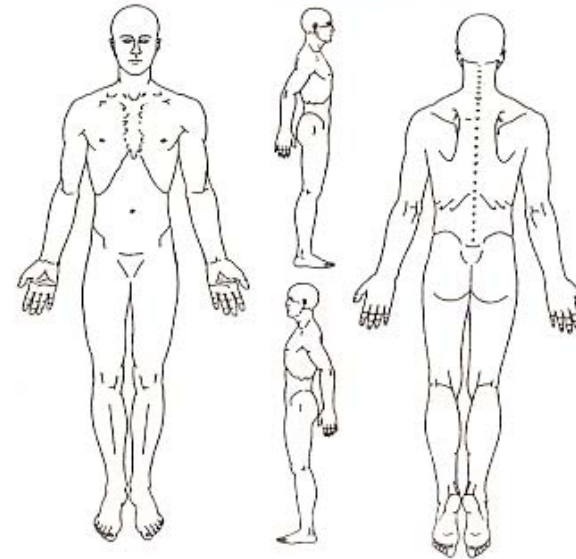
Patient Signature \_\_\_\_\_

## SECTION 2

Please mark below all areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas.

**Use the letters below to indicate the type and location of your sensations right now.**

A= ACHE	B= BURNING	N= NUMBNESS
P= PINS & NEEDLES	S= SHARPNESS	T= TIGHT/STIFF



Doctor's Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DTR (R/L) BC / TC / BR / PAT / ANK /

# New Patients Only

## SURGERY, HOSPITALIZATIONS AND TESTING

SURGERY/HOSPITALIZATION/MAJOR ILLNESS (Please include any metal implants or pace maker)

Reason for Hospitalization or Operation

Date

Doctor/Hospital

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Testing / Imaging

Date

Reason / Region of Body Tested

TESTING (BLOOD STUDY, URINALYSIS) /IMAGING (X-RAY, CAT SCANS, MRI)

_____	_____	_____
_____	_____	_____
_____	_____	_____

## CURRENT DAILY VITAMINS

---

---