Duxbury Sports Chiropractic and Fitness

HEALTH SELF ASSESSMENT

Please explain why are you here?

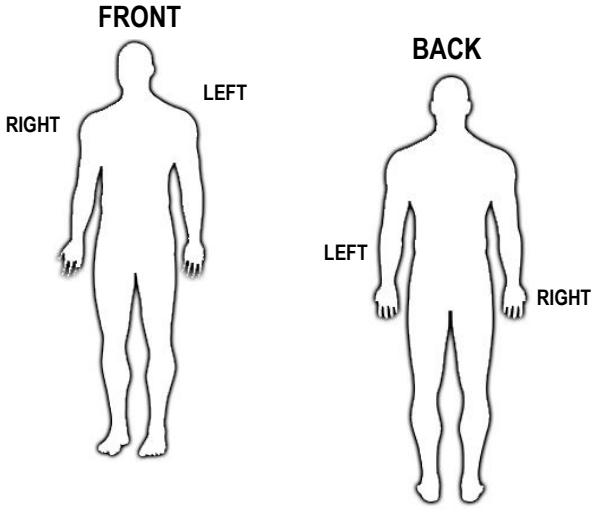
When did this issue/injury begin? / /
Have you ever had similar concerns in the past? ❑No ❑ Yes, If Yes, When? / /
Have you ever seen a Chiropractor before? ❑No ❑ Yes, If Yes, When? / / Doctor:

Use diagrams to indicate pain or numbness.

Draw an **X** for location of **pain**

Circle O areas of **numbness** and/or **tingling**

Use → to show if **pain travels** from one area to another



Rate your current level of pain with an X:

(0 = No Pain and 10 = Unbearable pain)

|---|---|---|---|---|---|---|---|---|---|---|
0 5 10

✓ all that apply:

My pain is: ❑Constant ❑Intermittent ❑Sharp ❑Dull ❑Stabbing ❑Burning ❑Other_____

I experience: ❑Numbness ❑Burning ❑Cramping ❑Tingling ❑Other_____

Symptoms/Concerns: Please ✓ all that you have experienced in past 6 months.

☐ Chest pain	☐ Mental dullness	☐ Shortness of breath	☐ Headache
☐ Irritability	☐ Blurry vision	☐ Pins/needles in hands	☐ Rib pain
☐ Back pain	☐ Head feels 'heavy'	☐ Pins/needles in feet	☐ Dizzy
☐ Confusion	☐ Arm/shoulder pain	☐ Pins/needles in arms	☐ Fainting
☐ Nervousness	☐ Cold hands/feet	☐ Pins/needles in legs	☐ Neck pain
☐ Constipation	☐ Neck restriction	☐ Pain while sitting	☐ Tension
☐ Depression	☐ Loss of taste	☐ Pain while standing	☐ Ear ringing

Signature: _____ Date: _____