Priority Wellness Care

Print Name: _____ **Date:** _____

WHICH OF THE FOLLOWING DESCRIBES YOUR PRESENT PROBLEM?
Please fill out as completely as possible so we know how best to help you!

❑ No obvious cause ❑ Sudden onset of pain: ❑Gradual onset ❑ An Illness ❑ An Injury ❑ A motor vehicle collision

❑ A personal injury 3rd party at fault ❑ A work related injury **Enter the date of the injury, illness or onset of pain:** _____

❑ On going Chiropractic care ❑ Wellness Care ❑ Other (describe): _____

In the blanks provided, list any **SYMPTOMS** that you experienced after the onset of pain, injury, or illness:
Then choose the appropriate 3 levels of pain descriptions.

Example: NECK PAIN ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ☑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ☑ Frequent ❑ Constant

Type of Pain: ❑ None ☑ Aching ❑ Burning ❑ Dull ❑ Pulling ☑ Sharp ❑ Shooting ❑ Stabbing ☑ Stinging ❑ Throbbing

---

1. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

2. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

3. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

4. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

5. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

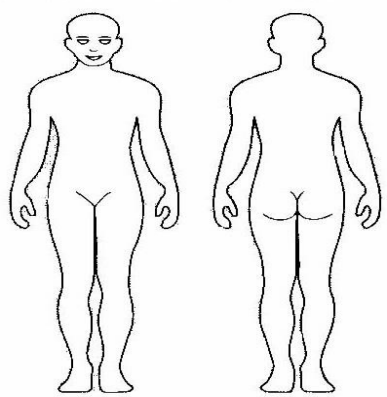
Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

6. _____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ None ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Type of Pain: ❑ None ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing

Draw in pain areas



Enter a Full Description of your Complaint, Condition, Accident, or Injury:

(when, where, how, & what hurts) _____

_____

_____

_____

_____

_____

_____

_____

_____

HABITS

❑Smoking Packs/day: _____

❑Alcohol/day): _____

❑CoffeeCups/Day: _____

❑Soda/Day: _____

❑Water Oz/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

Type Ex: _____

_____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑____
Father	❑	❑	❑	❑____
Brother(s)	❑	❑	❑	❑____
Sister(s)	❑	❑	❑	❑____

List any current medications you take: _____

_____

List any current supplements you take: _____

_____

List any current allergies: _____

_____

List any PAST surgeries? (enter the procedure and approximate date of surgery):

_____

_____

I hereby authorize the Doctor to examine me.

Print Name: _____ Date: _____

Patient's/Guardian's Signature: _____