Patient History: **Logan Valley Chiropractic, 1710 6th Avenue., Altoona, PA 16602 (814) 944-8483**

Patient Name _____ Today's Date ___/___/_____
Occupation _____ Date of Birth ___/___/_____

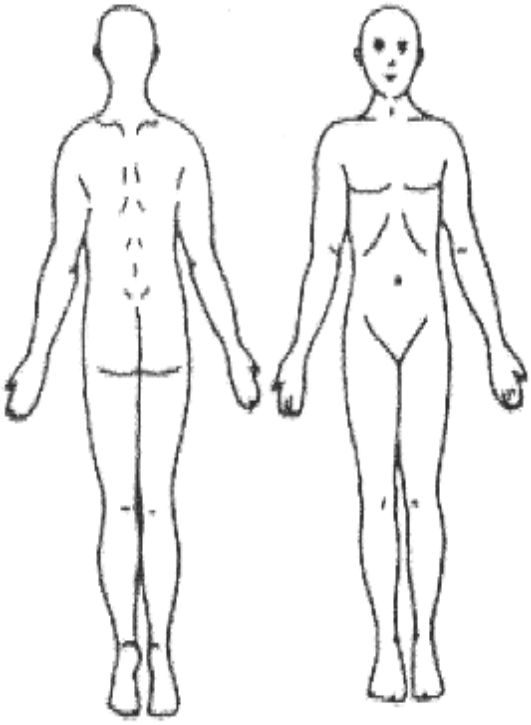
☐ Just seeking general wellness and prevention, no significant problem (SKIP THIS PAGE Go to Page 2)

1. Primary Complaint: _____

2. Are you currently treating with an MD for this condition? YES NO

3. Location: Show on the diagram the location of the pain, problem or discomfort using "X's".

4. Quality: How would you describe the pain or symptom? (Circle all that apply)
   Aching Burning Cramping Diffuse Dull Excruciating Numbness
   Pounding Pulsating Radiating Sharp Shooting Stabbing Stiffness
   Throbbing Tingling Tightness Weakness



5. Severity: On a scale from 0 to 10, with 10 being the worst possible, how would you rate your pain or problem NOW? (Circle one for each category)

   (0 = no pain, 1-3 = mild, 3-7 = moderate, 7-10 = Severe)
   Resting 0 1 2 3 4 5 6 7 8 9 10
   Active 0 1 2 3 4 5 6 7 8 9 10

   On average, how would you rate your pain over the last 2 weeks?
   Average 0 1 2 3 4 5 6 7 8 9 10

6. How long ago did it start? _____ days, weeks, months, years ago OR DATE ____/____/___

7. How did it start? (Circle One) Overexertion Repetitive Motion
   Slept Wrong Slip or Fall
   Other? _____

8. How often are you experiencing it? (Circle One)

Infrequently (less than daily)	Occasionally (1/4 of the time)	Intermittently (1/2 of the time)	Frequently (3/4 of the time)	Constantly (90-100%)

9. What makes it worse? (Circle all that apply)
   Pushing Pulling Movement Driving Bending Sitting Standing Lifting
   Kneeling Lying Down Coughing Sneezing Nothing Weight Bearing
   Looking Up Looking Down Walking Other: _____

10. What makes it better? (Circle all that apply)
    Activity Heat Ice Elevation Massage Standing Walking Resting Pain Meds
    Sitting Stretching Movement Immobilization Nothing Other: _____

11. Describe any other symptoms related to this problem: _____

12. Have you seen another Chiropractor? Who? _____ When?_____

Patient Name: _____ Date:_____

REQUIRED FOR INSURANCE

Daily Activities: Effects of Current Condition on Performance

No Effect ◄——————————————► Unable to Perform

	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
Bending:	□	□	□	□	□	□	□	□	□	□	□
Care –Infirm Family:	□	□	□	□	□	□	□	□	□	□	□
Carrying Groceries:	□	□	□	□	□	□	□	□	□	□	□
Change Posn–Sit-Stand:	□	□	□	□	□	□	□	□	□	□	□
Climb Stairs:	□	□	□	□	□	□	□	□	□	□	□
Driving:	□	□	□	□	□	□	□	□	□	□	□
Extended Computer Use:	□	□	□	□	□	□	□	□	□	□	□
Feeding:	□	□	□	□	□	□	□	□	□	□	□
Household Chores:	□	□	□	□	□	□	□	□	□	□	□
Kneeling:	□	□	□	□	□	□	□	□	□	□	□
Lift Children:	□	□	□	□	□	□	□	□	□	□	□
Lifting:	□	□	□	□	□	□	□	□	□	□	□
Pet Care:	□	□	□	□	□	□	□	□	□	□	□
Reading (Concentration):	□	□	□	□	□	□	□	□	□	□	□
Self Care:	□	□	□	□	□	□	□	□	□	□	□
Self Care–Bathing:	□	□	□	□	□	□	□	□	□	□	□
Self Care–Dressing:	□	□	□	□	□	□	□	□	□	□	□
Self Care–Shaving:	□	□	□	□	□	□	□	□	□	□	□
Sexual Activities:	□	□	□	□	□	□	□	□	□	□	□
Sleep:	□	□	□	□	□	□	□	□	□	□	□
Static Sitting:	□	□	□	□	□	□	□	□	□	□	□
Static Standing:	□	□	□	□	□	□	□	□	□	□	□
Walking:	□	□	□	□	□	□	□	□	□	□	□
Yard Work:	□	□	□	□	□	□	□	□	□	□	□

What other Daily Activities not listed above, do you have trouble with as a result of your problem?

No Effect ◄——————————————► Unable to Perform

	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
_____:	□	□	□	□	□	□	□	□	□	□	□
_____:	□	□	□	□	□	□	□	□	□	□	□
_____:	□	□	□	□	□	□	□	□	□	□	□

Recreational Activity: Effects of Current Condition on Performance

No Effect ◄——————————————► Unable to Perform

	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
_____:	□	□	□	□	□	□	□	□	□	□	□
_____:	□	□	□	□	□	□	□	□	□	□	□
_____:	□	□	□	□	□	□	□	□	□	□	□