Noble Sports Chiropractic, P.S. 1111 W. Holly St. Ste F., Bellingham, WA 98225   360.671.7067

Patient History Intake

Today's Date_____/_____/______

Describe where the pain is located____

Does is radiate? Yes____ No____ If yes, to where?____

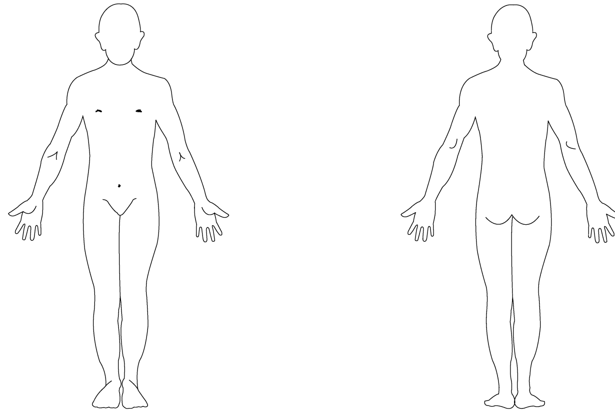
Please mark on the pain scale from 0 to 10 the pain you feel for this condition.

____

0 (no pain)   (worst pain imaginable) **10**

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	– – – – –
Pins & Needles	00000
Burning	xxxxx
Aching	*******
Stabbing	/ / / / /



Do you know how the injury occurred? Yes____ No____ If yes, please explain__________________________________

____

____

When did it occur?____________________________ GRADUAL or SUDDEN onset of pain? (please circle)

Did this occur at work? Yes____ No____ Is pain CONSTANT of INTERMITTENT? (please circle) % Intermittent_____

Worse in AM or PM? (please circle) Does the pain prevent you from sleeping? Yes___ No___

Is it getting WORSE or BETTER or SAME? (please circle)

Is pain MILD / MODERATE / SEVERE? (please circle)

Have you missed work? Yes____ No____ If Yes, How many days?____

Do you have a prior history of this injury or pain? Yes____ No____ If yes, please explain

____

What makes it better?____

What makes it worse? ____

Are you currently taking any medication? Yes____ No____ If yes, please list

____

Do you sleep on your BACK / STOMACH / SIDE? L or R side? (Please circle)

Are you currently being treated for this condition? Yes____ No____

Have you ever been treated for this condition before? Yes_____ No_____

Family History of Cancer, Heart Disease, Hypertension, Diabetes, Stroke? Yes(please circle) No____ If yes, what relation to you? ____

____

Treatment goals?____