Doctor _____
Date ____/_____/20____ Patient Name_____ Patient #_____

LIFE SPRING CHIROPRACTIC

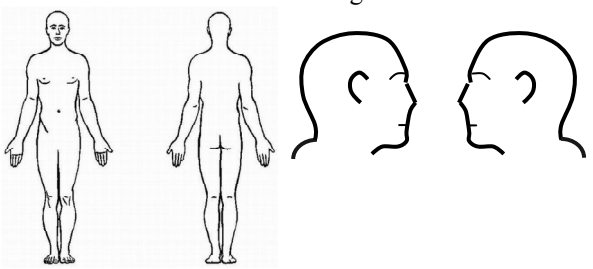
This flow chart gives the doctor a visual way of seeing what is bothering you. Please fill out anything you can.

What is bothering you? (list only one symptom per column)

1

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

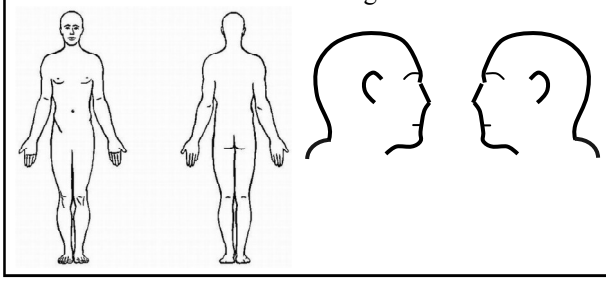
Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

2

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

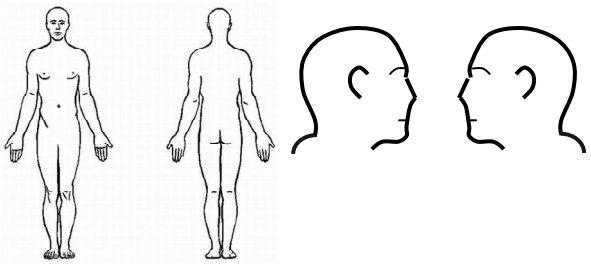
Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

3

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

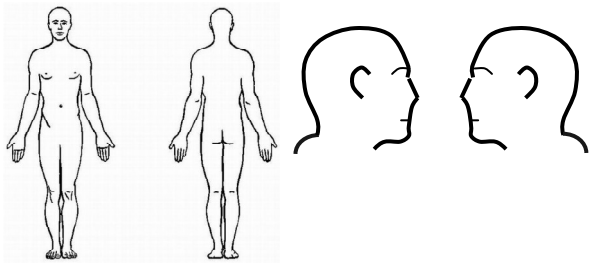
Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____

4

Mark an X where this symptom is:

Front Back Right Left



Name this symptom: _____

When did symptom start?
_____

How did it start? _____
_____
_____
_____

How frequently does it bother you?
❑Constant ❑Daily ❑Weekly
❑Monthly ❑Intermitted
❑Erratic ❑Other _____

What does it feel like?
❑Sharp ❑Shooting
❑Dull ❑Aching
❑Numb ❑Tingling
❑Burning ❑Stiffness
❑Other _____
_____
Does it Radiate down arms or legs ?_____
_____

Since onset, symptoms have:
❑Increased
❑Decreased
❑Remained the same
❑Erratic
❑Other _____

What makes it better? (example: certain time of day, position, medication, ice/heat, etc)
_____
_____

What makes it worse? (example: certain time of day, position, activities, etc.)
_____
_____
_____

What store bought or home remedies have you tried?
_____
_____
_____
_____
Effect? _____
_____
_____
Other professional care: ___
_____
_____
_____
Same or similar condition in the past? _____
_____

How are your day-to-day activities affected by this symptom?
_____
_____
_____
_____

Notes: _____
_____

On a 1-10 scale, what low end/high end range does your symptom bother you?
1 2 3 4 5 6 7 8 9 10
_____