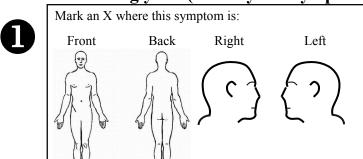
Doctor_				
Date	_/	/20	Patient Name	Patient #

IFE 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)



Front Back	•
Name this symptom:	
When did symptom start?  How did it start?  How frequently does it bother you  □Constant □Daily □Weekly	□ Burning □ Stiffness □ Other □  Does it Radiate down arms
□Monthly □Intermitted □Erratic □Other  What makes it better? (example: certain time of day, position, medication, ice/heat, etc)	Since onset, symptoms have:  □Increased □Decreased □Remained the same □Erratic □Other
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:
How are your day-to-day activities affected by this symptom?	Same or similar condition in the past?
Notes:	

	,,,
Notes:	

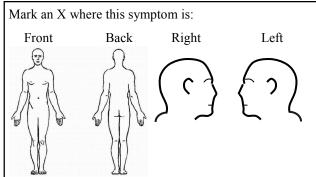
			what lov	w end/h	igh end	range d	loes you	ır sym	otom
1	ner you?	3	4	5	6	7	8	9	10

Mark an X w	here this symp	otom is:	
Front	Back	Right	Left
		(2)	£3

When did symptom start?	What does it feel like?  □Sharp □Shooting
How did it start?	□Dull □Aching □Numb □Tingling □Burning □Stiffness □Other
How frequently does it bother you? □Constant □Daily □Weekly □Monthly □Intermitted	Does it Radiate down arms or legs ?
□Erratic □Other	Since onset, symptoms hav
What makes it better? (example: certain time of day, position, medication, ice/heat, etc)	Remained the same Erratic Other
	What store bought or home remedies have you tried?
What makes it worse? (example: certain time of day, position, activities, etc.)	Effect?
	Other professional care:
How are your day-to-day activities affected by this symptom?	
	Same or similar condition i the past?

On	a 1-10	scale, v	vhat lov	w end/h	igh end	range d	loes you	ır sym	otom
botl	ner you'	?							
1	2	3	4	5	6	7	8	9	10



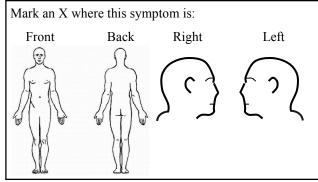


## Name this symptom:

When did symptom start?  How did it start?	What  Sha  Du  Nu  But  Oth
How frequently does it bother you? □Constant □Daily □Weekly □Monthly □Intermitted □Erratic □Other	Does or leg
What makes it better? (example: certain time of day, position, medication, ice/heat, etc)	□Dec □Rer □Erra □Oth
What makes it worse? (example: certain time of day, position, activities, etc.)	What remed
How are your day-to-day activities affected by this symptom?	Same the pa
Notes:	

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

Name this symptom:	
When did symptom start?  How did it start?	What does it feel like?  Sharp Shooting Dull Aching Numb Tingling Burning Stiffness Other
How frequently does it bother you? □Constant □Daily □Weekly □Monthly □Intermitted □Erratic □Other	Does it Radiate down arms or legs?  Since onset, symptoms have: □Increased
What makes it better? (example: certain time of day, position, medication, ice/heat, etc)	□Decreased □Remained the same □Erratic □Other
What makes it worse? (example: certain time of day, position, activities, etc.)	What store bought or home remedies have you tried?  Effect?
How are your day-to-day activities affected by this symptom?	Other professional care:
	Same or similar condition in the past?
Notes:	
On a 1-10 scale, what low end/high bother you?  1 2 3 4 5	end range does your symptom 6 7 8 9 10



When did symptom start?	What does it feel like?
How did it start?	□Sharp □Shooting □Dull □Aching □Numb □Tingling □Burning □Stiffness □Other
How frequently does it bother you? □Constant □Daily □Weekly □Monthly □Intermitted □Erratic □Other	Does it Radiate down a or legs ?Since onset, symptoms
What makes it better? (example: certain time of day, position, medication, ice/heat, etc)	☐ Increased ☐ Decreased ☐ Remained the same ☐ Erratic ☐ Other
What makes it worse? (example: certain time of day, position, activities, etc.)	What store bought or he remedies have you tried
How are your day-to-day activities affected by this symptom?	Other professional care
	Same or similar condition the past?
Notes:	