Nature's Way Chiropractic
Healing the Body the Natural Way

Interim History

Name:_____ **Date of Birth:**_____
Street Address:_____
City:_____**Zip:**_____
Phone #:_____**Okay to Text: Y / N**
Email:_____
Employer:_____**Occupation:**_____
Have there been any changes in your health history since you were last seen in our clinic?
(accidents, injuries, surgeries, illnesses, diseases, medications?)

_____
_____
_____

What are your current symptoms?

_____
_____
_____

When did your symptoms start?_____
What caused your symptoms to start?_____
_____
Is this related to an auto or work injury?_____

Circle the activities that make your pain worse:

Bending over	Driving	Exercising	Twisting
Walking	Weather	Using a computer	Lifting
Standing	Sleeping	Looking over Shoulder	Pushing
Sitting	Lying down	Reaching	Pulling

Circle the things that help reduce your pain and symptoms:

Cold packs	Heat packs	Stretching	Rest	Exercise
Pain medication	Anti-inflammatory medication		Sleep	Other:_____

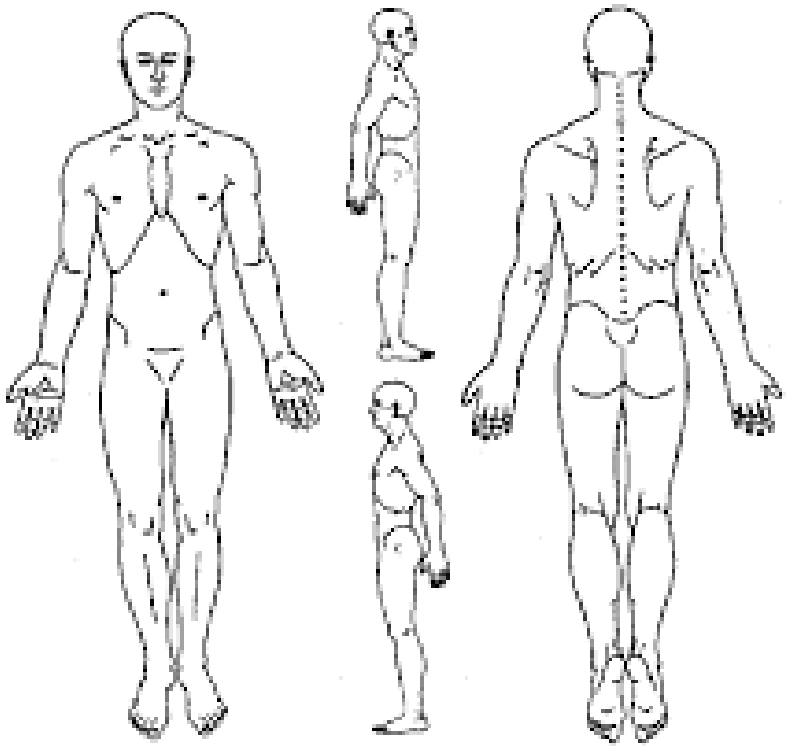
Describe your pain:

1. Constant	**2.** Worse in: Morning	**3.** Sharp	Shooting	Numbness
Frequent	Mid-day	Dull	Stiffness	Tightness
Occasional	Afternoon	Aching	Tingling	Boring
On & Off	Evening	Burning	Soreness	Deep

How would rate your pain today from 1-10 (1 = no pain; 10 = worst pain imaginable)

1 2 3 4 5 6 7 8 9 10

Please mark the diagram location the areas of pain:



Patient Informed Consent:

I _____, the undersigned patient, consent to the treatments(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature:_____ Date: _____