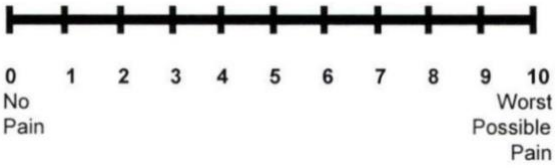
Chiropractic Office Visit

Today's Date: _____ Today's Provider: _____**DR. ARORA**_____

Your Name: _____ Date of Birth: _____

How much pain relief have you obtained?



Where is your pain located at today? _____

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

What word best describes the frequency of your pain? □ Constant □ Intermittent

When is your pain at its worst? □ Mornings □ During the day □ Evenings □ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

□ Enjoyment of Life □ Normal Work □ Sleep □ General Activity □ Mood

□ Recreational Activities □ Walking □ Relationship with people □ Other: _____

Changes since your last visit

Have you developed any new pain complaints? □ Yes □ No If yes, where? _____

How has your pain changed? □ Increased □ Decreased □ Same

What additional treatments have you done?

□ Procedure If so, what procedure(s)? _____

□ Physical Therapy How many treatments? _____

□ Chiropractic How many treatments? _____

□ Medication Which medication(s)? _____

Current Medications

Please list any changes since your last visit in the medications you are currently taking.

Medication: **Dosage:** **Date:**

_____

_____

_____