

Mammoth Chiropractic
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(760)934-4449

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____ Social Security# _____ Driver Lic.# _____
 Age _____ Birthdate ____/____/____ Sex M / F Status M S W D No. Children _____
 Occupation _____ Employer _____ Years Employed _____
 Address _____ City _____ State _____ Zip _____
 Spouse's Name _____ Occupation _____ Employer _____ Soc. Sec.# _____
 Person Responsible for this Account _____ Health Plan _____
 Subscriber's Name _____ ID# _____ Group# _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present? Describe your <u>current</u> pain/symptoms: Since it began, is your problem: What makes the problem better? What makes the problem worse? Can you perform your daily home activities? Do you exercise? Describe your job requirements: Can you perform your daily work activities? Describe your stress level: What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)	<input type="checkbox"/> Constantly <input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Improving <input type="checkbox"/> Nothing <input type="checkbox"/> Standing <input type="checkbox"/> Exercise <input type="checkbox"/> Nothing <input type="checkbox"/> Standing <input type="checkbox"/> Exercise <input type="checkbox"/> Yes <input type="checkbox"/> Yes, almost daily <input type="checkbox"/> Mainly sitting <input type="checkbox"/> Yes, all activities <input type="checkbox"/> None to mild	<input type="checkbox"/> Frequently <input type="checkbox"/> Throbbing <input type="checkbox"/> Soreness <input type="checkbox"/> Shooting <input type="checkbox"/> Tingling <input type="checkbox"/> Getting Worse <input type="checkbox"/> Lying Down <input type="checkbox"/> Sitting <input type="checkbox"/> Inactivity/rest <input type="checkbox"/> Lying Down <input type="checkbox"/> Sitting <input type="checkbox"/> Inactivity/rest <input type="checkbox"/> Yes, only with help <input type="checkbox"/> Yes, occasionally <input type="checkbox"/> Light Labor <input type="checkbox"/> Only some <input type="checkbox"/> Moderate	<input type="checkbox"/> Occasionally <input type="checkbox"/> Aches <input type="checkbox"/> Weakness <input type="checkbox"/> Gripping <input type="checkbox"/> Other _____ <input type="checkbox"/> No Change <input type="checkbox"/> Walking <input type="checkbox"/> Movement <input type="checkbox"/> Other _____ <input type="checkbox"/> Walking <input type="checkbox"/> Movement <input type="checkbox"/> Other _____ <input type="checkbox"/> Not at all <input type="checkbox"/> Not at all <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Not at all <input type="checkbox"/> High
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Have you had X-rays, MRI or other tests for this condition? What tests and When? _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



