

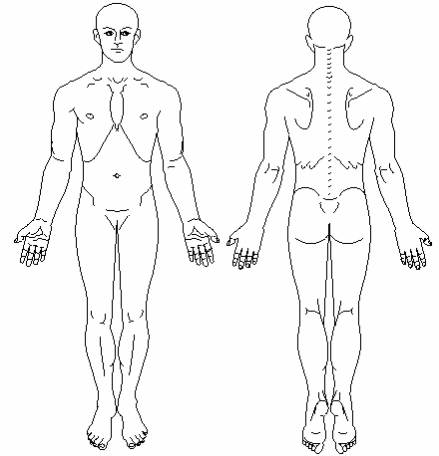
## Musculoskeletal History Form

Your Name: \_\_\_\_\_

Date: \_\_\_\_\_

What brings you in today for chiropractic care? \_\_\_\_\_

**Circle the location(s) of your symptoms**



Is your current problem the result of: Auto Accident? Yes No  
 Work Accident? Yes No  
 Slip & Fall? Yes No

**For EACH area of pain/complaint please answer the following questions:**

**Problem #1:** State problem (For example: low back pain) \_\_\_\_\_

When did it start? \_\_\_\_\_

What do you think is the cause? \_\_\_\_\_

Rate how severe your pain is **right now, at this moment**

0 1 2 3 4 5 6 7 8 9 10  
 No pain Most severe pain I can imagine  
 imagine

Rate how severe your pain is **at its worst**

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

Rate how severe your pain is **on the average**

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

Rate how **frequently** you experience pain

0 1 2 3 4 5 6 7 8 9 10  
 Rarely All of the time

**Describe pain:**  Sharp/Stabbing  Burning  Throbbing  Shooting  Tingling  Dull  Numb  Sore  Ache  Weak

**Since it began, is your problem:**  Improving  Getting Worse  No Change

**What makes your problem better?** Nothing Lying Down Standing Walking Sitting Movement Exercise  
 Inactivity/Rest Other \_\_\_\_\_

**What makes your problem worse?** Nothing Lying Down Standing Walking Sitting Movement Exercise  
 Inactivity/Rest Other \_\_\_\_\_

Can you perform your daily home and/or work activities: Yes, all activities Only with help A limited amount Not at all

Have you been treated for this recently? Yes No, If yes, what type of treatment? \_\_\_\_\_

Have you ever been treated for the same/similar problem? When? \_\_\_\_\_

**Problem #2:** (For example: neck back pain) \_\_\_\_\_

When did it start? \_\_\_\_\_

What do you think is the cause? \_\_\_\_\_

Rate how severe your pain is **right now, at this moment**

0 1 2 3 4 5 6 7 8 9 10  
 No pain Most severe pain I can imagine

Rate how severe your pain is **at its worst**

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

Rate how severe your pain is **on the average**

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

Rate how **frequently** you experience pain

0 1 2 3 4 5 6 7 8 9 10  
 Rarely All of the time

Your Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Problem #2 continued:**

**Describe pain:**  Sharp/Stabbing  Burning  Throbbing  Shooting  Tingling  Dull  Numb  Sore  Ache  Weak

**Since it began, is your problem:**  Improving  Getting Worse  No Change

**What makes your problem better?** Nothing Lying Down Standing Walking Sitting Movement Exercise  
Inactivity/Rest Other \_\_\_\_\_

**What makes your problem worse?** Nothing Lying Down Standing Walking Sitting Movement Exercise  
Inactivity/Rest Other \_\_\_\_\_

Can you perform your daily home and/or work activities: Yes, all activities Only with help A limited amount Not at all

Have you been treated for this recently? Yes No; If yes, what type of treatment? \_\_\_\_\_

Have you ever been treated for the same/similar problem? When? \_\_\_\_\_

What self-treatment have you tried? \_\_\_\_\_

**Problem #3:** (For example: Headache, Arm/leg pain, etc) \_\_\_\_\_

When did it start? \_\_\_\_\_

What do you think is the cause? \_\_\_\_\_

Rate how severe your pain is **right now, at this moment**  
0 1 2 3 4 5 6 7 8 9 10  
No pain Most severe pain I can imagine

Rate how severe your pain is **at its worst**  
0 1 2 3 4 5 6 7 8 9 10  
None Excruciating

Rate how severe your pain is **on the average**  
0 1 2 3 4 5 6 7 8 9 10  
None Excruciating

Rate how **frequently** you experience pain  
0 1 2 3 4 5 6 7 8 9 10  
Rarely All of the time

**Describe pain:**  Sharp/Stabbing  Burning  Throbbing  Shooting  Tingling  Dull  Numb  Sore  Ache  Weak

**Since it began, is your problem:**  Improving  Getting Worse  No Change

**What makes your problem better?** Nothing Lying Down Standing Walking Sitting Movement Exercise  
Inactivity/Rest Other \_\_\_\_\_

**What makes your problem worse?** Nothing Lying Down Standing Walking Sitting Movement Exercise  
Inactivity/Rest Other \_\_\_\_\_

Can you perform your daily home and/or work activities: Yes, all activities Only with help A limited amount Not at all

Have you been treated for this recently? Yes No; If yes, what type of treatment? \_\_\_\_\_

Have you ever been treated for the same/similar problem? When? \_\_\_\_\_

What self-treatment have you tried? \_\_\_\_\_

Describe your job requirements: Mainly Sitting Moving about Light Labor Heavy Labor Other: \_\_\_\_\_

Have you ever been in a motor vehicle accident? Yes No. **If yes, please complete the Motor Vehicle Accident Form.**

Please describe any other serious injuries you have had. Provide a year and a description of what body part was hurt, and what care, if any, you received: \_\_\_\_\_