Major Complaint Information

Date ____________________

Name you prefer:______________ How did you hear about BaxPlus?____________________

What is your major complaint(s)? ____________________

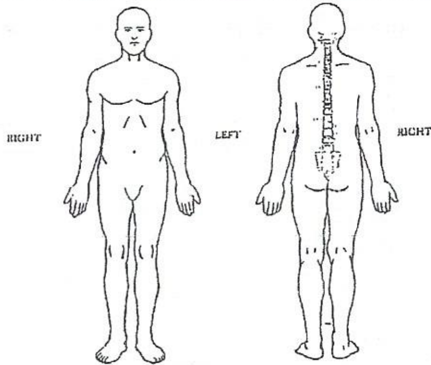
____

When did this symptom(s) begin? ____________________

Describe what happened____________________

Did these symptoms develop from? ☐ Auto Accident ☐ Work-Related Injury
Have you reported this to your: insurance company? ☐ Yes ☐ No employer? ☐ Yes ☐ No

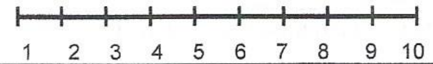
Mark your areas of pain using the Pain Index on the right.



Pain Index

P	Pain
B	Burning
St	Stabbing
S	Sharp
C	Constant

On a scale of 1-10 (1 being best, 10 being worst), please circle how bad the pain is when you feel the worst.



1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ☐ Yes ☐ No When? ____________________

What makes this condition feel worse? ____________________

What decreases the symptoms/pain? ____________________

Have you seen a doctor for this condition? ☐ Yes ☐ No Doctor's Name: ____________________
Date consulted: ____________________ Diagnosis:____________________

Does this condition interfere with your sleep? ☐ Yes ☐ No
If so, how many times do you wake up in pain per night? ________

In what position do you sleep? ☐ *Back* ☐ *Side* ☐ *Stomach*

Have you tried a heating pad? ☐ Yes ☐ No How does it affect the pain? ____________________

Have you tried a cold pack? ☐ Yes ☐ No How does it affect the pain? ____________________

Do you wear a heel lift? ☐ Yes ☐ No if so, which side? ☐ Right ☐ Left

Does it cause pain to cough, grunt or sneeze? ☐ Yes ☐ No If so, where? ____________________

Name of family physician: ____________________ Phone # ____________________

If female, are you pregnant? ☐ Yes ☐ No ☐ Not sure If yes, what is your due date: ____________________

Please check the activities that aggravate your complaint.

___ Lying on Back	___ Getting in/out of car	___ Sleeping	___ Stooping	___ Standing for periods over one hour
___ Lying on side with knees bent	___ Gripping	___ Pushing	___ Sitting	
	___ Climbing	___ Pulling	___ Bending forward	___ Sneezing
___ Turning over in bed	___ Dressing self	___ Reaching	___ Bending backward	___ Coughing
___ Lying flat on stomach	___ Kneeling	___ Walking		

Have you ever had any surgeries or hospitalizations? ☐ Yes ☐ No Please List:

Type of Hospitalization/Surgery: ______ Date: ______ Type of Hospitalization/Surgery: ______ Date: ______

Have you ever been seen by a chiropractor before? ☐ Yes ☐ No Please List:

Name of chiropractor: ______ Date: ______ Name of chiropractor: ______ Date: ______

Fill out the next three sections as they apply to you.

Headaches

Do you have a family history of headaches? ☐ Yes ☐ No Do you get headaches? ☐ Yes ☐ No Frequency ______

Do you experience the following along with your headaches: Pain or cracking in your jaw? ☐ Yes ☐ No

Abnormal blood pressure? ☐ Yes ☐ No ☐ High ☐ Low Nausea, Vomiting or Visual disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? ☐ 1-6 months ☐ 6-12 months ☐ 1-2 years ☐ over 2 years Results: ______

Lower Back

Do you ever experience ripping or tearing sensations in your back? ☐ Yes ☐ No If so, where? ______

Does pain radiate to the abdomen? ☐ Yes ☐ No

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No Explain: ______

Neck

If you have a neck injury, does it affect: (Check all that apply) ☐ hearing ☐ vision ☐ balance ☐ cause ringing in your ears

Do you hear grating sounds? ☐ Yes ☐ No Do you feel pressure or pain behind your eyes? ☐ Yes ☐ No

Do you feel ripping or tearing? ☐ Yes ☐ No Where? ______

Do you have difficulty lifting or turning your head? ☐ Yes ☐ No If so, in which direction? ☐ Right ☐ Left ☐ Up ☐ Down

Please check all additional complaints that you have at this time.

☐ Headache
☐ Loss of Concentration
☐ Eyes Sensitive to Light
☐ Memory Loss
☐ Heavy Feeling of Head
☐ Dizziness
☐ Ringing in Ears
☐ Loss of Balance
☐ Loss of Smell
☐ Loss of Taste
☐ Pain Behind Eyes
☐ Fainting
☐ Palpitation
☐ Neck Pain

☐ Neck Stiffness
☐ Neck Motion Restricted
☐ Upper Back Pain/Stiffness
☐ Mid Back Pain/Stiffness
☐ Lower Back Pain/Stiffness
☐ Right/Left Shoulder Pain
☐ Right/Left Arm Pain
☐ Right/Left Leg Pain
☐ Pins & Needles Arms/ Legs
☐ Vision Problems
☐ Sinus Trouble
☐ Nervousness
☐ Chest Pain
☐ Shortness of Breath

☐ Loss of Consciousness
☐ Irritable
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Fatigue
☐ Flushed Face
☐ Excess Perspiration
☐ Digestive Trouble
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Cold Hands

☐ Cold Feet
☐ Jaw Pain
☐ Cancer
☐ Hypertension
☐ Diabetes
☐ Hepatitis
☐ Convulsions
☐ Allergies (Please List)
______
______
______
☐ Anemia
☐ Heart Disease

☐ Arthritis
☐ HIV (Aids)
☐ Other (Please List)
______
______
______

Please Specify Location:
☐ Numbness ______
☐ Swelling ______
☐ Cuts ______
☐ Bleeding ______
☐ Broken Bones ______
☐ Bruising ______

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No
If so, please list : ______

Any additional information you would like the doctor to know about before beginning care at Baxplus? ______