Arctic Chiroprac	uc Juneau	rauenii N	ame:					Da	te:						
			SYMPTO	M HIST	ORY FOR	M									
Symptom 1 (ple	ase describe)	:													
On a scale from	0-10, with	10 as the wors	t, circle the	e numb	er that b	est descri	ibes th	ie sympto	om most	of the	time:				
0	1	2 3	4	5	6	7	8	9	10						
Circle what perc	entage of t	he time vou ar	e awake di	2 VOLL 6	vnerience	the aho	VA SVN	nntom at	the abov	ے بو inte	ancity:				
		25 30 35		-						\neg	insity.				
						70 73	00	85 50	<i>JJ</i> 100						
Did the sympto	_		=		-										
When did the s											-				
How did the sy	=	_									-				
Since the symp	_		_		_	worse, o	r stay	ing the s	same ? (c	ircle	one)				
What makes th	e symptor	•	cle all tha		<u> </u>										
Nothing		All movement			king down				king upwa						
Jumping/impact								ending backward at waist Turning at the waist Eaching overhead Reaching behind the bac							
Chewing		Prolonged posi		Lifti	_	ileau			ving	iiiu tii	e back				
Standing		unning Exercising													
Standing Walking Running Exercising Working Sitting Getting up from seated position Lying on side in bed									1						
Gripping		Squatting	her (please specify)												
Vhat makes th Nothing Walking Other (please de	Resting NSAIDs	Ice	cle relaxers	Hea	•		etching	ic adjustn	Exercise nents						
Describe the qu		o symptom (circle all t	nat ani	nlv):										
Sharp Dull	Achy	· · · · · ·		nging	Naggin	g Dee	ep a	Stabbing	Throbb	oing	Piercin				
Other (please de	•														
Does the symp If yes, was the symptom	here does	s the symptor	n radiate?	·				rES or	NO						
Morning	Midday	Afternoo		ening	Nigh				ne is wors	e tha	n other				
What provid and episode pri	•								ndition an						
MD/DO	Chiroprac	=	=			e injectior		Surge	-		ge thera				
_	Neurologi	st Massage	Therapist	1	Trigger p	oint injec	tions	Acupu	incture l	Physica	al Thera				
Orthopedist	_	t.a. N. :	. L.L.		CI.		D -	-	4D1		∵⊤ .				
Orthopedist ER/Urgent Care Other (specify)	Acupunct	urist Naturopa	ith None		Chiropra	ictic X- ion (specif	-Ray	N	⁄IRI	(CT scan				

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Arctic Chiropractic Juneau Patient Name:								Date:															
				S	ҮМРТ	ОМ	HIST	ORY I	ORN	/1													
Symptom 2	(plea	se describe):													-							
On a scale fr	om 0	-10, with	10 as th	e worst,	circle	the n	umb	er th	at be	st de	scrib	es th	ne sy	mpto	om mos	st of th	e time:						
	0	1	2	3	4		5	6		7		8		9	10								
Circle what p	oerce	ntage of	the time	you are a	awake	do v	ou e	xperi	ence	the a	abov	e svn	npto	m at	the ab	ove int	ensity:						
				35 40									-			\neg	,						
 Did the sym	ntor	n hegin (sudden	v or grad	dually	1 3 (ci	ircle	one)															
When did t		_			-																		
How did the																							
Since the sy	•	•		t been g e	etting	bet	ter. 8	etti	ng w	orse	e. or	stav	ing 1	the s	ame?	(circle	one)						
What make	-	_		_	_			_			.,	,				(0 00	, cc,						
Nothing		7		/ement				king d	ownv	vard				Loo	king up	ward							
Turning head	d		Bendin	Bending forward at waist					Bending backward at waist							Turning at the waist							
Jumping/imp	Jumping/impact Taking the stairs							Reaching overhead							Reaching behind the back								
Chewing	hewing Prolonged positions Lifting								Driving														
Standing			Walkin	Valking I				Running Exercising							unning						Exercising		
Working	Working Sitting Getting up from seated position Lying on side in be								d														
Gripping			Squatti	ng			Oth	er (ple	ease s	pecif	y)												
What make	s the	sympto	m bette	er? (circle	e all t	hat a	pply	/):															
Nothing Resting Ice H						Heat					ching			Exercise	5								
Walking Other (pleas	o dos	NSAIDs		Muscle	relaxe	ers	Mas	sage			Chirc	pract	tic ad	justm	nents								
Other (pleas	e ues	cribe)																					
Describe th	e qu	ality of t	ne symp	otom (cir	cle al	l tha	t app	oly):															
Sharp Du Other (pleas		Achy	Burnii	ng Sti	ff	Stingi	ing	Na	gging		Deep)	Stak	bing	Thro	bbing	Piercing						
Other (pieus	ic acs	cribe)																					
Does the sy	mpto	om radia	te to ar	other pa	art of	your	bod	ly (ci	rcle (one)	:	`	YES	or	NO								
If ye	es, wl	nere doe	s the sy	mptom	radiat	te? _						_											
Is the symp	tom	worse at	certair	times o	f the	dav (or ni	ght?	(circ	le al	l tha	t apı	(vla										
Morning		Midday		ternoon		Even			Night					ic tim	ne is wo	orse tha	an others						
		,					- 0		0 -														
■ What pro	ovide	rs have y	ou seen	for this co	onditi	on		■ V	Vhat	treat	tmer	its fo	r thi	s con	dition	and ep	isode hav						
and episod	e pric	or to toda	y's visit?	circle all	that a	pply)		you	had	prior	to t	oday	's vis	sit? (c	circle all	that ap	ply)						
MD/DO		Chiropra	ctor P	hysical The	eranist			Cort	isone	inier	tions	<u> </u>	ς	urger	·v	Massa	age therap						
Orthopedist		Neurolog		lassage Th					ger po					_	ncture		cal Therap						
ER/Urgent C		Acupunct		aturopath		-			oprac		X-F			-	1RI		CT scan						
Other (speci		-		<u>-</u>		one			licatio			•											
									ar Isn								No						

Reviewed by doctor: _____

Patient Name:	Date:

Patient-Specific Functional Scale

Please identify <u>up to five important activities</u> that you <u>are unable to do or have</u> <u>difficulty doing</u> as a result of your current symptoms. Write these down in the spaces provided below, then rate your ability to perform the activity in the last week by circling the appropriate number.

Activity 1:												
Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue
Activity 2:												
Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue
Activity 3:												
Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue
Activity 4:												
Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue
Activity 5_												
Unable to perform	0	1	2	3	4	5	6	7	8	9	10	Able to perform without issue