***Name*____*Date*____________________________**

Please fill out this form completely. For areas with no complaint please write NONE.

Doctor's Notes ______________

Neck

Do you have a neck complaint: Yes or No __________________________________
Rate the intensity of pain from 1-10 (10 = extreme pain, 1=very mild pain)______
Is the pain constant or does it come and go?__________________________________
Describe the pain(sharp, dull, ache, stabbing)_________________________________
Does anything seem to help the pain?_______________________________________
Does anything seem to make the pain worse?__________________________________
Does the pain radiate? (into arms, hands, etc)__________________________________
How often does the pain occur?____

Headache/Migraine (please circle)

Do you have headaches/migraines? Yes or No ______________________________
Rate the intensity of pain from 1-10. (10 = extreme pain, 1=very mild pain)______
Does anything seem to help the headache?___________________________________
Does anything seem to make the headache worse? ____________________________
Describe the headache(ache, dull, throbbing, stabbing, etc.)______________________
How often do you get a headache/migraine?____________________________________

Mid back pain

Do you have a midback complaint: Yes or No ______________________________
Rate the intensity of pain from 1-10. (10 = extreme pain, 1=very mild pain)______
Is the pain constant or does it come and go?__________________________________
Describe the pain(sharp, dull, ache, stabbing)_________________________________
Does anything seem to help the pain?_______________________________________
Does anything seem to make the pain worse?__________________________________
Does the pain radiate? (around your back, into your neck) ______________________
How often does the pain occur?____

Low back pain

Do you have a low back complaint: Yes or No______________________________
Rate the intensity of pain from 1-10 (10 = extreme pain, 1=very mild pain)______
Is the pain constant or does it come and go?__________________________________
Describe the pain(sharp, dull, ache, stabbing)_________________________________
Does anything seem to help the pain?_______________________________________
Does anything seem to make the pain worse?__________________________________
Does the pain radiate? (into legs, feet, etc) __________________________________
How often does the pain occur?____
Do you have problems with bowel/bladder control?____________________________

Arms/hands or Legs/Feet (please circle)

Do you have any extremity complaints: Yes or No __________________________
Which side: Left, Right or Both ____
Rate the intensity of pain from 1-10 (10 = extreme pain, 1=very mild pain)______
Is the pain constant or does it come and go?__________________________________
Describe the pain(sharp, dull, ache, stabbing)_________________________________
Does anything seem to help the pain?_______________________________________
Does anything seem to make the pain worse?__________________________________
How often does the pain occur?____

Are there any other health issues you would like to discuss with us? Please give details:____
____
____
____
____

Cornerstone Chiropractic ◆ Dr. Mike Ilyankoff ◆ Dr. Lisa Ilyankoff
2003 132nd Street SE, Ste. E, Everett, WA 98208 (425) 379-6301