Keystone Chiropractic

CHIEF Complaints or Symptoms **Name**_____ **Date:**_____

☐ **Neck pain:**

Check off the areas that the pain runs into from the neck

☐ none ☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand
☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand

☐ headache
☐ migraine headache
☐ upper back pain

Ringing in Ears	☐ yes	☐ no	☐ left	☐ right	☐ both ears
Blurry Vision	☐ yes	☐ no	☐ left	☐ right	☐ both eyes
Wrist Pain	☐ yes	☐ no	☐ left	☐ right	☐ both wrists
Jaw Pain	☐ yes	☐ no	☐ left	☐ right	☐ both sides

☐ dizziness ☐ nervousness ☐ fatigue ☐ anxiety ☐ depression ☐ excessive irritability
☐ fear of dring in a car ☐ a loss of concentration ☐ jaw clenching ☐ grinding of teeth at night
☐ nightmares ☐ difficulty with sleeping at night

Low Back Pain: ☐ none ☐ buttocks ☐ left buttock ☐ left thigh ☐ left knee
select the areas of radiation, if any.. ☐ left foot ☐ right buttock ☐ right thigh ☐ right knee ☐ right foot

hip pain	☐ left	☐ right	☐ bilateral
knee pain	☐ left	☐ right	☐ bilateral
foot pain	☐ left	☐ right	☐ bilateral

Numbness:

☐ left hand ☐ left upper arm ☐ right hand ☐ right upper arm
☐ left foot ☐ left leg ☐ right foot ☐ right leg

Additional Symptoms / Complaints: _____

_____

_____

_____

Have you lost any time from work due to your injuries? ☐ yes ☐ no
If yes please give dates:_____
Type of employment:_____
Have you had previous injuries or accidents? ☐ yes ☐ no
Description of previous accident: _____
Description of previous injuries: _____
Is there any residual pain from the previous injury? ☐ yes ☐ no
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____