

Knafla Chiropractic Clinic
History of Current Complaint

Name _____

Date _____ / _____ / _____

1) When did your symptoms start _____

2) How did your symptoms start _____

3) Describe your symptoms _____

4) Constant Frequent Occasional Intermittent

5) Pain Intensity 0 1 2 3 4 5 6 7 8 9 10

6) What makes your symptoms better _____

7) What makes your symptoms worse _____

8) Since onset are your symptoms getting
 Better Worse Staying same

9) Previous treatment	Date	Date
Medical Doctor	_____	X-Rays _____
Physical Therapy	_____	MRI _____
Chiropractor	_____	CT Scan _____
Massage Therapy	_____	

Location _____

10) Occupation _____

11) What are your goals for treatment?
