DATE

1° Complaint	2° Complaint
Location(s)	
Quality	
Dur.Freq.Timing	
Onset/Cause	
Acute/Chronic	
Aggr.	
Rel.	
NRS	
Pre.Diagnosis	
Pre.Therapy	
Injuries/Surgeries/Meds	

Other comments_____

_____

Current occupation_____

☐ Twisting/Bending ☐ Heavy lifting ☐ Sitting ☐ Standing

Previous occupations_____

Exercise and Sports_____

Hobbies_____

Patient's perception of own health_____

Diet: ☐ Adequate ☐ Inadequate

☐ Smoker

☐ Drinker

RED FLAGS	Y	Details	SYSTEM REVIEW	Y	Details
New headache	☐		Headaches	☐	
Vision	☐		Migraines	☐	
Hearing	☐		High blood pressure	☐	
Swallowing	☐		Palpitations	☐	
Speaking	☐		Shortness of breath	☐	
Dizziness	☐		Sinuses	☐	
Nauseous	☐		Prone to sickness	☐	
Weak/numb face/limbs	☐		Heartburn	☐	
Problems walking	☐		Indigestion	☐	
Night pain	☐		Nocturia	☐	
Night sweats	☐		Dysmenorrhoea	☐	
Lost weight	☐		Skin conditions	☐	
Travel	☐		Joints stiff/swollen	☐	
Saddle numbness	☐		Concentration	☐	
Bowel/bladder	☐		Mood	☐	
ALL OTHERS "NO"	☐		ALL OTHERS "NO"	☐	

Hereditary conditions_____

_____

Family/Living situation_____

_____