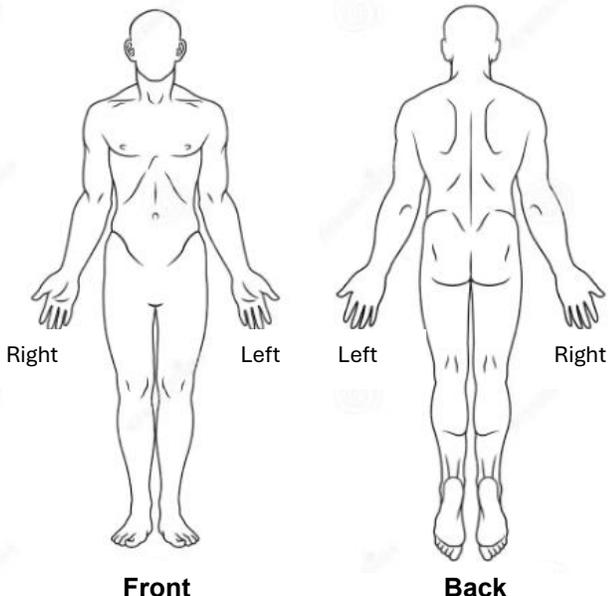


IANNUCILLI

CHIROPRACTIC

INJURIES/SYMTOMS

Please mark the area(s) of injury or discomfort on the images below. Indicate the degree of pain on all marked areas using a scale of 1 (least pain) for 10 (severe pain).



What are the symptoms you are experiencing?
Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Arn/Shoulder Pain | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Feet/Toe Numbness | <input type="checkbox"/> Sleep Difficulty |
| <input type="checkbox"/> Hand/Finger Numbness | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vision Blurred |

Type of Pain – Check all that apply:

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Other: _____ |

Is this condition getting progressively worse? Yes No Is it constant? Yes No

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down
 Reaching Lifting Pushing/Pulling Prolonged Postures

MEDICAL HISTORY

Have you ever been in an accident before? Yes No (if yes, explain) _____

Do you take medication? Yes No (if yes, list:) _____

Do you have any health problems? Yes No (if yes, explain:) _____

Have you ever had surgery? Yes No (if yes, explain:) _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change and health.

Signature of Patient, Parent, or Guardian

Date

Please print name of Patent, Parent or Guardian

Relationship to Patient