

**BACKCOUNTRY CHIROPRACTIC**  
 1354 NW GALVESTON AVE ♦ BEND OR 97701  
 (541) 385-5900 ♦ Fax (541) 385-6900

**History of Injury:**

*(Please describe your problem, its location, and how it began)*

Date problem began: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current/Previous Conditions and Treatment:**

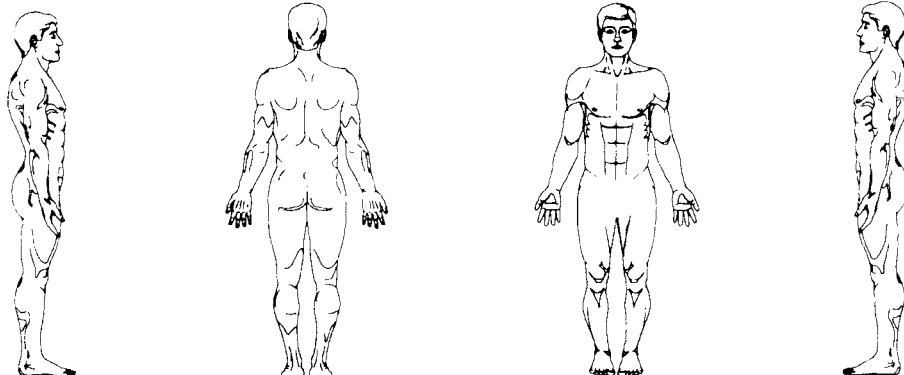
*(Surgery, medications, injections, therapy, chiropractic)*

**X-rays, MRI, Other Tests for this Condition**

*(What Tests and When?)*

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10	
	No Pain										Unbearable Pain	
How often are your symptoms present?	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Intermittently	<input type="checkbox"/> Occasionally								
Describe your <u>current</u> pain/symptoms:	<input type="checkbox"/> Sharp/Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Numbness	<input type="checkbox"/> Burning	<input type="checkbox"/> Improving	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Yes
	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Soreness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Tingling	<input type="checkbox"/> Getting Worse	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Inactivity/rest	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Sitting	<input type="checkbox"/> inactivity/rest	<input type="checkbox"/> Yes, only with help
	<input type="checkbox"/> Aches	<input type="checkbox"/> Weakness	<input type="checkbox"/> Gripping	<input type="checkbox"/> Other _____	<input type="checkbox"/> No Change	<input type="checkbox"/> Walking	<input type="checkbox"/> Movement	<input type="checkbox"/> Other _____	<input type="checkbox"/> Walking	<input type="checkbox"/> Movement	<input type="checkbox"/> Other _____	<input type="checkbox"/> Not at all
	<input type="checkbox"/> Sharp/Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Numbness	<input type="checkbox"/> Burning	<input type="checkbox"/> Improving	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Yes, almost daily
Since it began, is your problem:	<input type="checkbox"/> Improving	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Yes, all activities	
What makes the problem better?	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise
What makes the problem worse?	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Nothing	<input type="checkbox"/> Standing	<input type="checkbox"/> Exercise
Can you perform your daily home activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes, only with help	<input type="checkbox"/> Yes, occasionally	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Only some	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> Not at all	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Not at all	<input type="checkbox"/> High
Do you exercise?	<input type="checkbox"/> Yes, almost daily	<input type="checkbox"/> Yes, occasionally	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Only some	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> Not at all	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> High
Describe your job requirements:	<input type="checkbox"/> Mainly sitting	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Only some	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> High
Can you perform your daily work activities?	<input type="checkbox"/> Yes, all activities	<input type="checkbox"/> Only some	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> High
Describe your stress level:	<input type="checkbox"/> None to mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> High	<input type="checkbox"/> High	<input type="checkbox"/> Not at all	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Not at all	<input type="checkbox"/> High	<input type="checkbox"/> High

**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING**



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_