CHRISTIAN FAMILY CHIROPRACTIC CENTER
Dr. Billy R. Lyon, DC, 909 862-8888
7231 Palm Ave, Highland, CA 92346 ~ www.doccfcc.com

PATIENT'S PRESENT COMPLAINTS

Name _____ File#_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____ _____

_____

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?	☐ Constantly	☐ Frequently	☐ Occasionally ☐ Intermittently
Describe your current pain/symptoms:	☐ Sharp/Stabbing ☐ Dull ☐ Numbness ☐ Burning	☐ Throbbing ☐ Soreness ☐ Shooting ☐ Tingling	☐ Aches ☐ Weakness ☐ Gripping ☐ Other _____
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/rest	☐ Walking ☐ Movement ☐ Other _____
What makes the problem worse?	☐ Nothing ☐ Standing ☐ Exercise	☐ Lying Down ☐ Sitting ☐ Inactivity/rest	☐ Walking ☐ Movement ☐ Other _____
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

_____

_____

Have you had X-rays, MRI or other tests for this condition? What tests and When? _____

_____

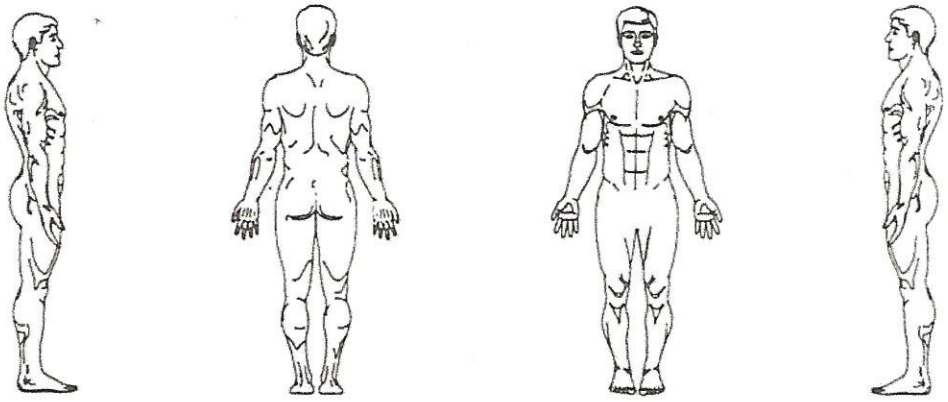
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING

Current Weight:

____

Current Height:

____



Patient Signature: _____ Date: _____

Continued on Reverse

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PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Patient ID# _____

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Wrist Pain (R_____ L_____)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstral Flow
☐	☐	Profuse Menstral Flow
☐	☐	Breast ☐Soreness ☐Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date) _____
☐	☐	Stroke (date) _____
☐	☐	Asthma
☐	☐	Cancer, Explain_____
☐	☐	Tumor, Explain_____
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other_____

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer ☐ Epilepsy
☐ Rheumatoid Arthritis ☐ Chronic Back Problems
☐ Diabetes ☐ Chronic Headaches
☐ Heart Problems ☐ Lupus
☐ Lung Problems ☐ Other_____
☐ High Blood Pressure _____

Yes	No	
☐	☐	Do you have a permanent disability rating? Location _____
☐	☐	Date rating received ____/____/____
☐	☐	Rating Percentage_____%

Present Weight _____pounds **Height** _____feet _____inches

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # births_____
☐	☐	Birth Control Pills, type_____
☐	☐	Medications (list if not listed elsewhere) _____ _____
☐	☐	Hospitalizations/Surgical Procedures (list if not described elsewhere)_____

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: _____ Date: _____