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

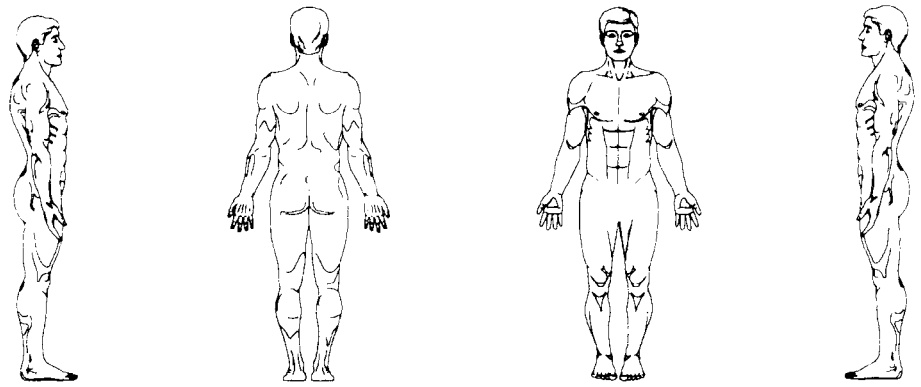
(What Tests and When?)

_____

How bad is your pain? (Circle a number)	0 No Pain	1	2	3	4	5	6	7	8	9	10 Unbearable Pain

How often are your symptoms present?	□ Constantly	□ Frequently	□ Intermittently	□ Occasionally
Describe your current pain/symptoms:	□ Sharp/Stabbing	□ Throbbing	□ Aches	
	□ Dull	□ Soreness	□ Weakness	
	□ Numbness	□ Shooting	□ Gripping	
	□ Burning	□ Tingling	□ Other _____	
Since it began, is your problem:	□ Improving	□ Getting Worse	□ No Change	
What makes the problem better?	□ Nothing	□ Lying Down	□ Walking	
	□ Standing	□ Sitting	□ Movement	
	□ Exercise	□ Inactivity/rest	□ Other _____	
What makes the problem worse?	□ Nothing	□ Lying Down	□ Walking	
	□ Standing	□ Sitting	□ Movement	
	□ Exercise	□ inactivity/rest	□ 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	

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



Patient Signature:_____ Date:_____