

# Change of Condition Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

There are many reasons why people seek chiropractic care and sometimes it's due to a pain or other type of symptom. Our focus is on helping you regain the EASE you have lost, because of subluxation (Spinal misalignment and Nerve stress/tension). Please fill-out each question below completely, so we can best help you.

List any falls, slips, strains, flare-ups, injuries or other traumas you had since your last appointment:

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When did this new condition(s) begin?

Date \_\_\_\_\_ Approximate Time \_\_\_\_\_

Where did this new event/condition happen?

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What have you done to try to relieve your symptoms?

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Have you received any other care for newly reported condition(s)? Y N

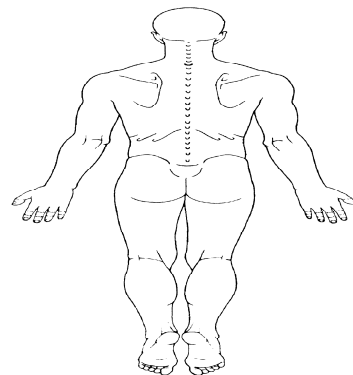
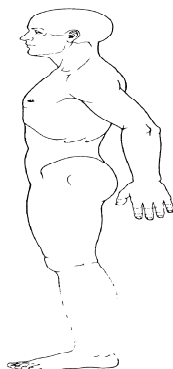
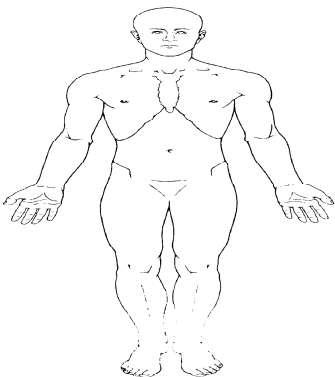
If Yes...

Where? \_\_\_\_\_ By whom? \_\_\_\_\_

## PAIN/DISCOMFORT LOCATION

Please mark off the areas of your complaint on the diagram BELOW. Please use the following symbols on the pain diagram to accurately describe your condition.

- \* Where you experience Pain
- N Where you experience Numbness
- T Where you experience Tingling
- B Where you experience Burning
- C Where you experience Cramping



Turn page over to share further information about the condition(s) you are newly reporting today.

**Problem/Complaint:**

**Pain/Discomfort Level:** *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain*

**The frequency of this problem? (Circle)** 0 10 20 30 40 50 60 70 80 90 100 (%) of your *Day or Week*

**Is this problem worse in the** *Morning / by Midday / at the end of the day / at night / Sleep time / anytime*

**Does this problem radiate/move elsewhere?** Y N If Yes, where?  
\_\_\_\_\_

**Quality/feel of the problem? (Circle)** Dull - Sharp - Throbbing - Burning - Deep - Aching  
Tingling - Stabbing - Cramping - Numbness - Radiating  
Sore - Tense - Other \_\_\_\_\_

**Aggravating Factors: (Circle)**

Sitting - Standing - Walking - Bending - Stooping - Lifting  
Sleeping - Sneezing - Coughing - Straining - Reaching - Twisting  
Looking up - Looking down - Movement - Rest - Lying on back - Driving  
Computer use - Scooping - House chores - Exercise - Lying on your stomach  
Stair stepping - Other \_\_\_\_\_

**Relieving Factors: (Circle)**

Sitting - Standing - Lying down - Keeping knees bent - Support of any kind - No movement  
Movement - Heat pack - Warm/hot shower - Ice pack - Analgesic topical cream  
Ibuprofen - Other Medication \_\_\_\_\_ - Rest - Stretching/Exercise - Adjustments  
Other \_\_\_\_\_

Any other comments:

**Problem/Complaint:**

**Pain/Discomfort Level:** *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain*

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Any other comments:

Sign: \_\_\_\_\_