"3John2"
RAPHA CLINIC
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8. Since your symptoms began, have they: Improved___ Worsened___ Stayed the same___

9. Are your symptoms constant? Yes _____ No _____
If there are Any times or positions when you do not experience your pain/discomfort (e.g. after exercising or resting, while sleeping),
Please explain _____

10. What aggravates your current symptoms (physical overuse, mental stress, prolonged sitting, standing, bending)? _____

11. Is your sleep disturbed by these symptoms? Yes ____ No ____ Sometimes ____

12. Have you done anything to try to help or relieve your complaint, such as bed rest, heat, cold, aspirin, medications, sitting, lying down, or other? Please describe.
_____

13. Have you ever-received treatment for this condition? No _____ Yes _____
If yes, whom did you see? _____
Where were you seen? _____
Were x-rays taken? No _____ Yes _____ (Where?) _____
What type of treatment was done? _____
How much did it help? [0 ---------- 10]
No improvement Full improvement

14. Please put a mark on the scale to show how bad your usual discomfort has been recently.
If you are describing more than one symptom, indicate the level of pain for each symptom.

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

15. Have you seen a doctor of chiropractic or osteopath for any other conditions?
No _____ Yes _____ If yes, please describe. _____

16. Are you aware of any blood relatives (your parents, brothers, or sisters) with similar discomfort or conditions? No _____ Yes _____
If yes, please describe. _____

17. Are your symptoms the result of an auto accident, work injury or other personal injury? Auto accident _____ Work related _____ Other _____

I hereby authorize doctors and staff of Rapha Spine & Neuro Center to examine, diagnose, and treat me (my dependent/minor child), and to take any necessary x-rays that are clinically indicated.

Patient's Signature: X _____ Date:_____