Dr. Scott E Yorker D.C.

HISTORY

Name:_____ Date:_____

Primary Complaint:_____
Date of Onset:_____ Same/Similar complaints before this episode: □ Yes □ No

History of complaint:_____
_____
_____
_____
_____
_____

Quality of Pain: □ Dull □ Sharp □ Shooting □ Throbbing □ Burning □ Numbing
□ Tingling □ Stabbing □Pins and Needles □ Deadness □ Stiffness
□Cramping □ Other _____
Frequency: □ Constant □ Frequent □ Intermittent □ Occasional
Intensity of Pain: (0-10): 10 = Severe:_____
Radiation of Pain: □ No □ Yes _____
Aggravates: □ AM □ PM □ Bending □ Twisting □ Sitting □ Standing □ Lying
□ Walking □ Neck Movements □ Stress □ Coughing □ Getting out of bed
□ Other_____
Relieves: □ AM □ PM □ Lying □ Walking □ Resting □ Sleeping □ Heat □ Cold
□ Pain Pills □ Other_____
Prior treatment for this complaint:_____
Prior chiropractic in your lifetime: □ Yes □ No _____

Headache History: □ Primary complaint □ Secondary complaint □ Not a complaint
Onset:_____
Location: □ Temporal □ Occipital □ Frontal □ Retroorbital □ Other_____
Frequency: □ Constant □ Daily □ Frequent □ Occasional _____
Quality: □ Dull □ Sharp □ Stabbing □ Throbbing □ Other_____
Symptoms: □ Photophobia □ Nausea □ Visual effects □ Dizziness □ Vomitting
Initial Assessment: □ Cervicogenic □ Migraine □ Cluster □ Sinus □ Occular
□ Other_____

Other Comments:

_____
Doctor's Signature

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