Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

Patient Name ______________________________ Date ______________

ADDITIONAL SYMPTOMS

Use the following if your answers to questions 1 through 5 of the INTAKE or UPDATE FORM vary for each Body Area(s) / Symptom(s) you listed.

Body Area / Symptom(s) #2: ______________________

What caused this condition? (Check appropriate boxes):

☐ Not sure ☐ After a long drive / flight ☐ Yard work
☐ Sports Injury ☐ After a poor night's sleep ☐ Sitting too long
☐ Auto Accident ☐ After lifting an object ☐ Prolonged illness
☐ Work Injury ☐ Reaching or overarching ☐ Household chores
☐ After a slip / fall ☐ Other (explain) ______________

On a scale from 0 to 10, with 10 being the worst, circle the number that best describes your symptom(s) most of the time:

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

Circle the percent of the day you feel your symptom(s):

☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Most recent date or time period your symptom(s) began: ____________

What was the onset of your symptom(s)? ☐ Gradual ☐ Sudden

Have you had this same condition before? ☐ No ☐ Yes

If yes, when? ______________________, and what was the intensity (0-10 w/ 10 the worst) ______, and frequency (percent of day)? ______%.

Check ALL that aggravate your symptom(s):

☐ Bending Neck Forward ☐ Tilting Left at Waist ☐ Sitting
☐ Bending Neck Backward ☐ Tilting Right at Waist ☐ Standing
☐ Tilting Head to Left ☐ Twisting Left at Waist ☐ Lifting
☐ Tilting Head to Right ☐ Twisting Right at Waist ☐ Driving
☐ Turning Head to Left ☐ Getting Up from Sitting ☐ Walking
☐ Turning Head to Right ☐ Changing Positions ☐ Running
☐ Bending Forward at Waist ☐ Climbing Stairs ☐ Chewing
☐ Bending Backward at Waist ☐ Any Movement
☐ Other (explain) ______________________

Check ALL that relieve your symptom(s):

☐ Nothing ☐ Heat ☐ Standing ☐ Physical Therapy
☐ Resting ☐ Stretching ☐ Pain Medication ☐ Chiropractic
☐ Sitting ☐ Exercise ☐ Muscle Relaxers ☐ Massage
☐ Ice ☐ Walking ☐ Other (explain) ______________

Check ALL that describe your symptom(s):

☐ Dull ☐ Burning ☐ Shooting ☐ Throbbing
☐ Achy ☐ Stabbing ☐ Stinging ☐ Tight / Spasms
☐ Stiff ☐ Deep ☐ Numb ☐ Pins / Needles
☐ Sharp ☐ Nagging ☐ Tingling ☐ Other (explain) ________

Is the symptom(s) worse at certain times? (check ALL that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ Unaffected by the time of day

Does the symptom(s) radiate, shoot or travel to another part of your body?

☐ No ☐ Yes If yes, where? ______________________

Body Area / Symptom(s) #3: ______________________

What caused this condition? (Check appropriate boxes):

☐ Not sure ☐ After a long drive / flight ☐ Yard work
☐ Sports Injury ☐ After a poor night's sleep ☐ Sitting too long
☐ Auto Accident ☐ After lifting an object ☐ Prolonged illness
☐ Work Injury ☐ Reaching or overarching ☐ Household chores
☐ After a slip / fall ☐ Other (explain) ______________

On a scale from 0 to 10, with 10 being the worst, circle the number that best describes your symptom(s) most of the time:

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

Circle the percent of the day you feel your symptom(s):

☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Most recent date or time period your symptom(s) began: ____________

What was the onset of your symptom(s)? ☐ Gradual ☐ Sudden

Have you had this same condition before? ☐ No ☐ Yes

If yes, when? ______________________, and what was the intensity (0-10 w/ 10 the worst) ______, and frequency (percent of day)? ______%.

Check ALL that aggravate your symptom(s):

☐ Bending Neck Forward ☐ Tilting Left at Waist ☐ Sitting
☐ Bending Neck Backward ☐ Tilting Right at Waist ☐ Standing
☐ Tilting Head to Left ☐ Twisting Left at Waist ☐ Lifting
☐ Tilting Head to Right ☐ Twisting Right at Waist ☐ Driving
☐ Turning Head to Left ☐ Getting Up from Sitting ☐ Walking
☐ Turning Head to Right ☐ Changing Positions ☐ Running
☐ Bending Forward at Waist ☐ Climbing Stairs ☐ Chewing
☐ Bending Backward at Waist ☐ Any Movement
☐ Other (explain) ______________________

Check ALL that relieve your symptom(s):

☐ Nothing ☐ Heat ☐ Standing ☐ Physical Therapy
☐ Resting ☐ Stretching ☐ Pain Medication ☐ Chiropractic
☐ Sitting ☐ Exercise ☐ Muscle Relaxers ☐ Massage
☐ Ice ☐ Walking ☐ Other (explain) ______________

Check ALL that describe your symptom(s):

☐ Dull ☐ Burning ☐ Shooting ☐ Throbbing
☐ Achy ☐ Stabbing ☐ Stinging ☐ Tight / Spasms
☐ Stiff ☐ Deep ☐ Numb ☐ Pins / Needles
☐ Sharp ☐ Nagging ☐ Tingling ☐ Other (explain) ________

Is the symptom(s) worse at certain times? (check ALL that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ Unaffected by the time of day

Does the symptom(s) radiate, shoot or travel to another part of your body?

☐ No ☐ Yes If yes, where? ______________________

My initials certify that the above information is true and complete to the best of my knowledge. **Patient (or Guardian's) initials**______ **Date**__________

Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

Patient Name ____ Date ____________________

ADDITIONAL SYMPTOMS

Use the following if your answers to questions 1 through 5 of the INTAKE or UPDATE FORM vary for each Body Area(s) / Symptom(s) you listed.

Body Area / Symptom(s) #4: ______________________________

What caused this condition? (Check appropriate boxes):

- ☐ Not sure ☐ After a long drive / flight ☐ Yard work
- ☐ Sports Injury ☐ After a poor night's sleep ☐ Sitting too long
- ☐ Auto Accident ☐ After lifting an object ☐ Prolonged illness
- ☐ Work Injury ☐ Reaching or overarching ☐ Household chores
- ☐ After a slip / fall ☐ Other (explain) ______________________

On a scale from 0 to 10, with 10 being the worst, circle the number that best describes your symptom(s) most of the time:

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

Circle the percent of the day you feel your symptom(s):

☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Most recent date or time period your symptom(s) began: ____________

What was the onset of your symptom(s)? ☐ Gradual ☐ Sudden

Have you had this same condition before? ☐ No ☐ Yes

If yes, when? ______________________, and what was the intensity (0-10 w/ 10 the worst) ______, and frequency (percent of day)? ______%.

Check ALL that aggravate your symptom(s):

- ☐ Bending Neck Forward ☐ Tilting Left at Waist ☐ Sitting
- ☐ Bending Neck Backward ☐ Tilting Right at Waist ☐ Standing
- ☐ Tilting Head to Left ☐ Twisting Left at Waist ☐ Lifting
- ☐ Tilting Head to Right ☐ Twisting Right at Waist ☐ Driving
- ☐ Turning Head to Left ☐ Getting Up from Sitting ☐ Walking
- ☐ Turning Head to Right ☐ Changing Positions ☐ Running
- ☐ Bending Forward at Waist ☐ Climbing Stairs ☐ Chewing
- ☐ Bending Backward at Waist ☐ Any Movement
- ☐ Other (explain) ________________________________

Check ALL that relieve your symptom(s):

- ☐ Nothing ☐ Heat ☐ Standing ☐ Physical Therapy
- ☐ Resting ☐ Stretching ☐ Pain Medication ☐ Chiropractic
- ☐ Sitting ☐ Exercise ☐ Muscle Relaxers ☐ Massage
- ☐ Ice ☐ Walking ☐ Other (explain) ______________

Check ALL that describe your symptom(s):

- ☐ Dull ☐ Burning ☐ Shooting ☐ Throbbing
- ☐ Achy ☐ Stabbing ☐ Stinging ☐ Tight / Spasms
- ☐ Stiff ☐ Deep ☐ Numb ☐ Pins / Needles
- ☐ Sharp ☐ Nagging ☐ Tingling ☐ Other (explain) ________

Is the symptom(s) worse at certain times? (check ALL that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

☐ Unaffected by the time of day

Does the symptom(s) radiate, shoot or travel to another part of your body?

☐ No ☐ Yes If yes, where? ____________________

Body Area / Symptom(s) #5: ______________________________

What caused this condition? (Check appropriate boxes):

- ☐ Not sure ☐ After a long drive / flight ☐ Yard work
- ☐ Sports Injury ☐ After a poor night's sleep ☐ Sitting too long
- ☐ Auto Accident ☐ After lifting an object ☐ Prolonged illness
- ☐ Work Injury ☐ Reaching or overarching ☐ Household chores
- ☐ After a slip / fall ☐ Other (explain) ______________________

On a scale from 0 to 10, with 10 being the worst, circle the number that best describes your symptom(s) most of the time:

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

Circle the percent of the day you feel your symptom(s):

☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Most recent date or time period your symptom(s) began: ____________

What was the onset of your symptom(s)? ☐ Gradual ☐ Sudden

Have you had this same condition before? ☐ No ☐ Yes

If yes, when? ______________________, and what was the intensity (0-10 w/ 10 the worst) ______, and frequency (percent of day)? ______%.

Check ALL that aggravate your symptom(s):

- ☐ Bending Neck Forward ☐ Tilting Left at Waist ☐ Sitting
- ☐ Bending Neck Backward ☐ Tilting Right at Waist ☐ Standing
- ☐ Tilting Head to Left ☐ Twisting Left at Waist ☐ Lifting
- ☐ Tilting Head to Right ☐ Twisting Right at Waist ☐ Driving
- ☐ Turning Head to Left ☐ Getting Up from Sitting ☐ Walking
- ☐ Turning Head to Right ☐ Changing Positions ☐ Running
- ☐ Bending Forward at Waist ☐ Climbing Stairs ☐ Chewing
- ☐ Bending Backward at Waist ☐ Any Movement
- ☐ Other (explain) ________________________________

Check ALL that relieve your symptom(s):

- ☐ Nothing ☐ Heat ☐ Standing ☐ Physical Therapy
- ☐ Resting ☐ Stretching ☐ Pain Medication ☐ Chiropractic
- ☐ Sitting ☐ Exercise ☐ Muscle Relaxers ☐ Massage
- ☐ Ice ☐ Walking ☐ Other (explain) ______________

Check ALL that describe your symptom(s):

- ☐ Dull ☐ Burning ☐ Shooting ☐ Throbbing
- ☐ Achy ☐ Stabbing ☐ Stinging ☐ Tight / Spasms
- ☐ Stiff ☐ Deep ☐ Numb ☐ Pins / Needles
- ☐ Sharp ☐ Nagging ☐ Tingling ☐ Other (explain) ________

Is the symptom(s) worse at certain times? (check ALL that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

☐ Unaffected by the time of day

Does the symptom(s) radiate, shoot or travel to another part of your body?

☐ No ☐ Yes If yes, where? ____________________

My initials certify that the above information is true and complete to the best of my knowledge. Patient (or Guardian's) initials______ Date____________