



**Hoffman Chiropractic**

8731 Shoal Creek Blvd

Austin, Texas 78757

512-346-5164

## CHIEF COMPLAINTS OR SYMPTOMS

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

|   |   |  |  |                                       |                                    |
|---|---|--|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Neck Pain                        | <input type="checkbox"/> none           | <input type="checkbox"/> left shoulder | <input type="checkbox"/> left arm      | <input type="checkbox"/> left forearm | <input type="checkbox"/> left hand |
| check off the areas that the pain runs into from the neck | <input type="checkbox"/> right shoulder | <input type="checkbox"/> right arm     | <input type="checkbox"/> right forearm | <input type="checkbox"/> right hand   |                                    |
| <input type="checkbox"/> headache                         |   |  |  |                                       |                                    |
| <input type="checkbox"/> Migraine Headache                |   |  |  |                                       |                                    |
| <input type="checkbox"/> upper back pain                  |   |  |  |                                       |                                    |

|                 |                              |                             |                               |                                |                                      |
|-----------------|------------------------------|-----------------------------|-------------------------------|--------------------------------|--------------------------------------|
| Ringing in Ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both Ears   |
| Blurry vision   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both Eyes   |
| Wrist Pain      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both Wrists |
| Jaw Pain        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Both Side   |

Dizziness  nervousness  fatigue  anxiety  depression  excessive irritability  
 fear of driving a car  a loss of concentration  jaw clenching  grinding of teeth at night  
 nightmares  difficulty with sleeping at night

|  |                                    |  |                                       |                                     |                                     |
|--|------------------------------------|--|---------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Low Back Pain   | <input type="checkbox"/> none      | <input type="checkbox"/> buttocks      | <input type="checkbox"/> left buttock | <input type="checkbox"/> left thigh | <input type="checkbox"/> left knee  |
| select the areas of radiation, if any... | <input type="checkbox"/> left foot | <input type="checkbox"/> right buttock | <input type="checkbox"/> right thigh  | <input type="checkbox"/> right knee | <input type="checkbox"/> right foot |

|           |                               |                                |                                    |
|-----------|-------------------------------|--------------------------------|------------------------------------|
| Hip Pain  | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Bilateral |
| Knee Pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Bilateral |
| Foot Pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Bilateral |

**Numbness/Tingling**  
 Left Hand  Left Upper Arm  Right Hand  Right Upper Arm  
 Left Foot  Left Leg  Right Foot  Right Leg

Additional Symptoms/Complaints: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you lost any time from work due to your injuries? Yes No  
 If yes please give dates \_\_\_\_\_  
 Type of employment \_\_\_\_\_  
 Have you had previous injuries or accidents? Yes No  
 Description of previous accident \_\_\_\_\_  
 Description of previous injuries \_\_\_\_\_  
 Is there any residual pain from the previous injury? Yes No  
 How much better did you feel prior to your current condition?( Example 100%, 80% etc. ) \_\_\_\_\_

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