ALOHA WELLNESS
12915 JONES-MALTSBERGER RD, STE 604, SAN ANTONIO, TEXAS 78247

Patient Name: _____ **Date:** _____

Patient History:

1) What/where is your complaint? _____
_____
2) Does it travel to your arms, legs or head? Yes ____ No ____
IF YES: Where does it go? _____
3) On a scale from 0-10, with 0 being no pain, 10 being the worst pain imaginable), how bad was your pain when it first started? ____ / 10
4) On a scale from 0-10,how bad is it now? ____ / 10
5) Describe the pain/complaint (le: sharp/burning/achy): _____
_____
6) Is it constant or does it come and go? ___constant ___ comes/goes
7) What makes it better? _____
_____
8) What makes it worse? _____
_____
9) How did this happen? _____
_____
_____
_____
10) When did this happen? _____
11) Have you had this pain/complaint before? Yes ____ No ____
IF YES: When? _____
What caused it? _____
Did you receive any treatment? Yes ____ No ____
IF YES: What was done? _____
12) Has anyone treated you for this complaint? Yes ____ No ____
IF YES: Who & When: _____
What was done? _____
Why did you stop going? _____
13) Have you ever been treated by a chiropractor? Yes ____ No ____
IF YES: Who & When: _____
IF YES:Same complaint? Yes ____ No ____
IF NO: What were you treated for? _____
Why did you stop going? _____
14) Do you have <u>any</u> heart or circulation problems? Yes ____ No ____
IF YES: What problems? _____
15) Have you ever had a stroke? Yes ____ No ____
IF YES: When? _____
16) What are you taking, if any, medications? _____
Over-the-counter? _____
Supplements? _____

Notes

(Doctor Use Only)

Init. _____ Date _____

Signature: _____ ***Date:*** _____

DR. CLAYTON L CLARK, DC, ACN