Step Up Chiropractic
1110 University Ave, Ste 403, Honolulu, HI 96826

ABOUT THE PATIENT

Name _____ Today's Date_____ Birthdate _____ Age_____
Address _____ City _____ State _____ Zip_____
Cell Phone _____ Gender ❑ M ❑ F ❑ Other / prefer not to answer
Occupation _____ Employer _____
e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes
Emergency Contact _____ ph # _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often are symptoms felt (check one): ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Staying the same ❑ Getting worse ❑ Worse in morning ❑ Worse in evening
❑ Pain radiates to_____

2. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often is the pain felt (check one): ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Staying the same ❑ Getting worse ❑ Worse in morning ❑ Worse in evening
❑ Pain radiates to_____

3. _____ How long has this been an issue? _____
Pain intensity (circle one): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
How often is the pain felt (check one): ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Staying the same ❑ Getting worse ❑ Worse in morning ❑ Worse in evening
❑ Pain radiates to_____

4. Do you expect any long trips or permanent moves off island that may interfere with adhering to care? _____
5. Does your condition affect: ❑ Standing ❑ Sitting ❑ Walking ❑ Work ❑ Lifting Things ❑ Sleep ❑ Other _____
6. What makes it better?_____
7. What makes it worse? _____
8. What other health practitioners have you seen for this?_____
_____
9. Any other things you have tried to fix this issue:_____
_____

NOTES: _____
_____
_____
_____
_____
_____

Are you pregnant?
❑ Yes ❑ No

Please mark all areas of concern.