Complaint Form Side 2: Please complete both sides of this form

Gardiner Family Chiropractic 90 Main Avenue, Gardiner, Me 04345 (207) 582-2222

Full Name:_____ Date:_____

Are you complaints affecting your ability to do any of the following?

This section to be completed by PATIENT			This section to be complete by DOCTOR		
Check if affected by		Activity	Full with no pain		UTP due to pain
Complaint 1	Complaint 2				
		Bending		Degrees w/o pain	
		Carrying		__Light / __med / __heavy w/ pain	
		Driving		Minutes w/o pain	
		Headaches	NONE	__ HAs per __ week __month	CONSTANT
		Housework		Minutes w/o inc. pain	
		Picking up objects		Weight of object w/o inc. pain	
		Lying		Minutes w/o pain	
		Opening jars		w/o inc pain: __Light / __med / __heavy	
		Personal care		__Extra Pain / __Pain + Slow & careful / __Need some help	DAILY ASST
		Pulling		Pounds w/o inc. pain	
		Pushing		Pounds w/o inc. pain	
		Reaching		___Degrees __above / __below shoulder level w/o pain	
		Reaching behind		Degrees w/o pain	
		Reading		_Normal with _slight / _mod pain increase _Less than normal w/ _mod / _severe pain	
		Recreation		_V. little / _Few / _Major / _All but pain	
		Running		_____ _Yards / _Miles w/o inc. pain	
		Shopping		Minute w/o increased pain	
		Sit to stand	Any w/o inc. pain	_Lazy boy / _Low / _Med / _High w/o pain	Painful, need assistance for any
		Sitting		Hours before having pain	
		Sleeping		Loss of __ hours d/t pain	
		Standing		Minutes w/o pain	
		Throwing		% effort w/o pain	
		Walking		_10 / _50 / _100 feet ; _ 1 block; _1/2 / _ 1 or more miles	
		Writing		Minutes w/o inc. pain	
		Yardwork		Minutes w/o pain	
		Other:			
		Other:			
		Other:			

Medications you are currently taking. If there are no current medications, check here: _____

Medication name	Reason	Dosage	Medication name	Reason	Dosage

___Copy of current mediation list attached (We are happy to take a copy if you have a current list with you)

**Please update us should your medications change in any way or if you are prescribed new medications.

List any known allergies you have (to medications or otherwise). If no allergies are known, check here**:** _____

_____

Female Patients:

Are you currently pregnant? Y / N If yes, due date: Do you take birth control pills? Y / N If yes, brand:

Number of pregnancies: Number of children: Ages:

Are you taking hormone/estrogen replacement? Y / N If yes, how long?