Neepawa / Minnedosa Chiropractic Centre

Dr. Mark Perrett B.Sc., D.C **Dr. Beth Melendy B.Sc., D.C**

Patient Name:_____ **Date:**_____

Have you seen a chiropractor before? Yes No

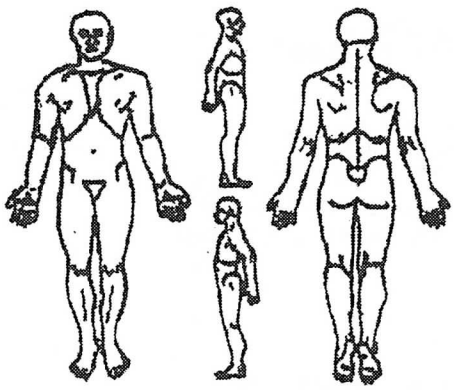
Pain/Discomfort Diagram:

Presenting Complaint(s): _____

Please circle the description of your pain:

Dull & Achy	Burning	Pins & Needles
Stiff & Tight	Sharp & Stabbing	Numbness

Please indicate on the diagram the location of your pain or discomfort:



Pain Intensity:

Please rate the pain that you are experiencing on a scale of 0 to 10. Zero being no pain and ten the worst pain possible.

0 1 2 3 4 5 6 7 8 9 10

Pain Intensity:

Do you smoke?	Yes	No	(cigarettes/day_____)
Do you drink coffee?	Yes	No	(cups/day_____)
Do you exercise?	Yes	No	(days/week_____)
Do you consume alcohol?	Yes	No	(drinks/day_____)
Do you drink soda?	Yes	No	(drinks/day_____)

Rate your sleep, hours per night:	4-6	6-8	8-10	12+	
Do you wake well rested?	Yes	No			
Would you consider your stress to be:	Mild	Moderate	Severe		
Rate your appetite (circle):	Poor	Fair	Medium	Good	Excellent
Rate your diet (circle):	Poor	Fair	Medium	Good	Excellent
Do you eat regularly? (circle)	Poor	Fair	Medium	Good	Excellent
Do you eat per day (circle):	1 Meal	2 Meals	3 Meals	4 Meals	More then 4 Meals
Do you follow any particular diet? (circle)	Yes	No	Vegetarian	High Protein	Low Fat Other_____

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