

**Ottawa Village Chiropractic, PLC**  
**Greg Lynas, DC**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Date: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

<p>What is your main complaint?</p> <p>_____</p> <p>_____</p> <p>Describe in detail.</p> <p>_____</p> <p>_____</p> <p>When is it most troublesome?</p> <p>_____</p> <p>Does it "come and go"?</p> <p>_____</p> <p>If so, at predictable times?</p> <p>_____</p> <p>When did it begin?</p> <p>_____</p> <p style="padding-left: 20px;">Date _____</p> <p>What caused it? _____</p> <p>Was it work related? _____</p> <p>Was it related to an auto accident?</p> <p>_____</p> <p>Was it related to an injury?</p> <p>_____</p> <p>Have you seen any other doctor, since it began?</p> <p>_____</p> <p>If so, other doctors' names and Addresses</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>What relieves this problem?</p> <p>_____</p> <p>When does it bother you most?</p> <p>_____</p> <p>What do you expect our care to accomplish?</p> <p>_____</p> <p>Indicate any secondary complaint.</p> <p>_____</p> <p>_____</p> <p>Describe in detail.</p> <p>_____</p> <p>_____</p> <p>When is it most troublesome?</p> <p>_____</p> <p>Do you have any other complaints or conditions?</p> <p>_____</p> <p>_____</p> <p>Describe in detail.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Printed Name</p> <p>_____</p> <p>Signature</p> <p>_____</p>
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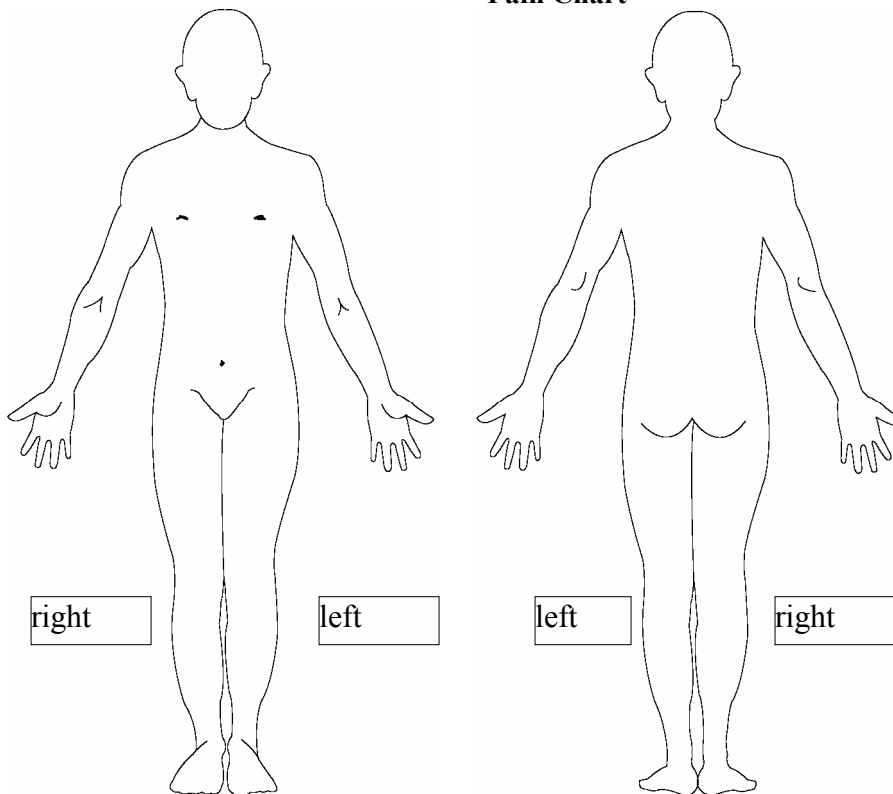
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.  
 Use the appropriate symbols.  
 Mark areas of radiation.  
 Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.  
 10 being the worst pain you have felt with this condition.

**Pain Chart**



**Neck-Shoulder-Arm-Pain**

On a scale of zero to 10, I rate my discomfort as follows:

( \_\_\_\_\_ )  
 0 10  
 no pain severe pain

**Mid Back Pain**

On a scale of zero to 10, I rate my discomfort as follows:

( \_\_\_\_\_ )  
 0 10  
 no pain severe pain

**Low Back and Leg Pain**

On a scale of zero to 10, I rate my discomfort as follows:

( \_\_\_\_\_ )  
 0 10  
 no pain severe pain

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

\_\_\_\_\_  
 Signature