Perrault Chiropractic Offices, Inc. **Problem Detail Form** Date: _____

Patient Name: _____ **Date of Birth:** _____

To best help the doctor to understand your problem complete this form in detail.

Describe ONLY 1 problem on this page - Use a separate form for each problem area.

Where do you feel the problem? _____

_____

What caused the problem? _____

When did this begin? _____

Circle the level of pain you have been experiencing. (0 = No pain, 10 = Excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

What activities of daily living are most affected? ☐ Employment ☐ Homemaking ☐ Lifting
☐ Personal Care ☐ Sitting ☐ Sleeping ☐ Social life ☐ Standing ☐ Traveling and/or Driving
☐ Walking ☐ Other: _____

What tasks do you have difficulty performing due to this problem (Check all that apply): ☐ Bending over
☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing self ☐ Driving car ☐ Exercising
☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping ☐ Performing household chores
☐ Lifting ☐ Looking over shoulder ☐ Lying down ☐ Making love ☐ Reaching overhead
☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing ☐ Staying asleep
☐ Using a computer ☐ Walking ☐ Yard work ☐ Other: _____

_____

My pain is:

☐ Dull	☐ Stabbing	☐ Deep	☐ Sharp	☐ Sharp with movement
☐ Throbbing	☐ Burning	☐ Aching	☐ Soreness	☐ Pulling
☐ Cramping	☐ Numbness	☐ Tingling	☐ Pinprick	☐ Radiating
☐ Tightness	☐ Pressure	☐ Stiffness	☐ Weakness	☐ Pins and needles
☐ Heaviness	☐ Shooting	☐ Pinching	☐ Other: _____	

The pain has been: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Off and on ☐ Random ☐ Recurring
My pain is at its worst in the: ☐ morning ☐ afternoon ☐ evening ☐ at night

Does the pain radiate? ☐ No ☐ Yes, the pain radiates to: _____

My pain is:

☐ Dull	☐ Sharp	☐ Sharp with movement	☐ Stabbing
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What helps relieve the problem?
☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage ☐ Nothing
☐ Over the counter medication ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ Other: _____

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Have you had previous episodes of this problem? ☐ No ☐ Yes _____

Have you had care previous to coming here for this problem? ☐ No ☐ Yes _____

Have you had recent diagnostic tests for this problem? ☐ No ☐ Yes _____

Returning Patients: Since you were last here, any new Surgeries, Traumas, Illnesses or Medications?

☐ No ☐ Yes _____

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