

**Performance and Spine Chiropractic Center, LLC**  
**19365 SW 65<sup>th</sup> Ave. Suite 104 Tualatin, OR 97062**  
**PHONE (503) 486 – 5199**  
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**Jonathan Kinney D.C., Member**  
**Heather Kinney D.C., Member**

**INITIAL COMPLAINT**

Initial here if Re-exam \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Primary Care Physician & Clinic: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Doctors treating you for this condition: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Therapists treating you for this condition: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Date of initial onset for this condition: \_\_\_\_\_ If reoccurrence, date of current aggravation: \_\_\_\_\_  
 Describe how the injury occurred: \_\_\_\_\_

When did your problem begin?  Immediately after a specific incident  Multiple incidents  Gradually developed

No specific incident - Please list the "incident/s": \_\_\_\_\_

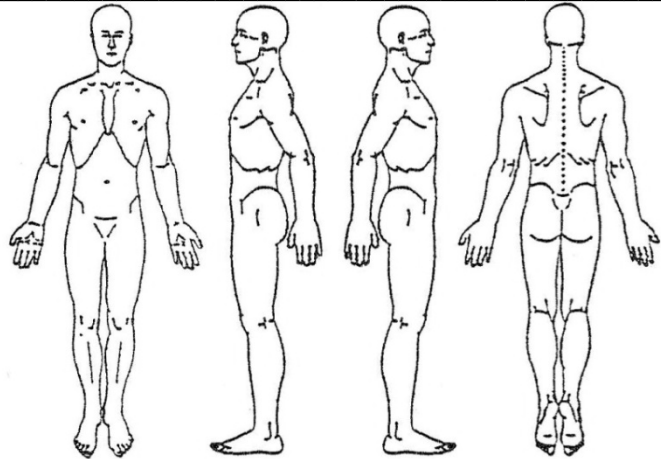
**Pain Diagram:** Use symbols below to mark the figures.

**Description:**

- XX = Aching
- /// = Numbness
- >>> = Stabbing
- ### = Burning
- 000 = Pins/Needles
- TTT = Throbbing

**Frequency (overall):**

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)



**Rate Intensity as Follows (This Section):**

- |                              |  |  |
|------------------------------|--|--|
| 0 None                       | 4 Moderate, bothers during work/activities | 8 Intense, preoccupied, seeks relief instead of activity |
| 1 Maybe                      | 6 Limiting, prevents full activity         | 10 Severe—on bed rest, stops all activity                |
| 2 Mild, forgotten w/activity |  |  |

Is it getting  Better  Worse  No Change?

**Complaint** (I.e. Neck Pain, Low Back Pain, etc) Place "X" for average pain, "O" worst pain, "□" pain now

1. \_\_\_\_\_ 0...1...2...3...4...5...6...7...8...9...10  
 2. \_\_\_\_\_ 0...1...2...3...4...5...6...7...8...9...10  
 3. \_\_\_\_\_ 0...1...2...3...4...5...6...7...8...9...10  
 4. \_\_\_\_\_ 0...1...2...3...4...5...6...7...8...9...10

**Your general stress level:**  No stress  Minimal stress  Moderate stress  Greatly stressed

**Physical activity at work:**  Sitting more than 50% of day  Light manual labor  Manual labor  Heavy manual labor

**General physical activity:**  No regular exercise program  Light exercise program  Strenuous exercise program

**Please describe any other physical/emotional/hormonal medical concerns that you are considering seeking care for, currently receiving care for, or in the past have sought care for:**

Patient signature Date →→→→(please see other side) \_\_\_\_\_ / \_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Initial: \_\_\_\_\_ Condition Continued... \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Dr Initial: \_\_\_\_\_

← For Re-exams/Updates Only—please initial if there has been no change since your last visit. →

**For ALL new patients and patients who have had a new injury please answering the following.**

If you have ever been treated for a listed condition in the past, please check it in the Past column.

If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

- | <table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> </tr> <tr> <td><input type="checkbox"/> Neck Pain (723.1)</td> <td><input type="checkbox"/> Aortic Aneurysm (441.5)</td> </tr> <tr> <td><input type="checkbox"/> Shoulder Pain (719.41)</td> <td><input type="checkbox"/> High Blood Pressure (401.9)</td> </tr> <tr> <td><input type="checkbox"/> Pain in Upper Arm or Elbow (719.42)</td> <td><input type="checkbox"/> Angina (413.9)</td> </tr> <tr> <td><input type="checkbox"/> Hand Pain (719.44)</td> <td><input type="checkbox"/> Heart Attack (410.9)</td> </tr> <tr> <td><input type="checkbox"/> Wrist Pain (719.43)</td> <td><input type="checkbox"/> Stroke (436)</td> </tr> <tr> <td><input type="checkbox"/> Upper Back Pain (724.1)</td> <td><input type="checkbox"/> Asthma (493.9)</td> </tr> <tr> <td><input type="checkbox"/> Low Back Pain (724.2)</td> <td><input type="checkbox"/> Cancer (199.1)</td> </tr> <tr> <td><input 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|--|--|---------|--|--|---|--|--|---|---|---|--|---------------------------------------|--|---|--|---|--|--|--|--|---|---|---|---|---|--|---|---|--|---|--|---|--|--|---|--|---|------|---------|--|---|--|--|---|---|---|--|--------------------------------|--|--|---|---|---|--|--------------------------------------|---|--|--|---|--|--|---|---|
| Past   | Present  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Neck Pain (723.1)   | <input type="checkbox"/> Aortic Aneurysm (441.5)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Shoulder Pain (719.41)  | <input type="checkbox"/> High Blood Pressure (401.9)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Pain in Upper Arm or Elbow (719.42)   | <input type="checkbox"/> Angina (413.9)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Hand Pain (719.44)  | <input type="checkbox"/> Heart Attack (410.9)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Wrist Pain (719.43)   | <input type="checkbox"/> Stroke (436)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Upper Back Pain (724.1)   | <input type="checkbox"/> Asthma (493.9)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Low Back Pain (724.2)   | <input type="checkbox"/> Cancer (199.1)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Pain in Upper Leg or Hip (719.45)   | <input type="checkbox"/> Tumor (229.9)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Pain in Lower Leg or Knee (729.5)   | <input type="checkbox"/> Prostate Problems (601.9)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Pain in Ankle or Foot (719.47)  | <input type="checkbox"/> Blood Disorder (790.6)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Jaw Pain (526.9)  | <input type="checkbox"/> Emphysema (chronic lung disorders) (492.8)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Swelling/Stiffness of Joint(s)  | <input type="checkbox"/> Arthritis (716.9)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Fainting (780.2)  | <input type="checkbox"/> Rheumatoid Arthritis (714.0)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Visual Disturbances (368.9)   | <input type="checkbox"/> Diabetes (250.0)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Convulsions (780.3)   | <input type="checkbox"/> Epilepsy (349.5)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Dizziness (780.4)   | <input type="checkbox"/> Ulcer (556.9)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Headache (784.0)  |  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| Past   | Present  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Colitis (558.9)   | <input type="checkbox"/> Anorexia (307.1)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Irritable Colon (564.1)   | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain (783.1) <input type="checkbox"/> Loss (783.2) |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> HIV/AIDS (042)  | <input type="checkbox"/> Excessive Thirst (783.5)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Systemic Lupus  | <input type="checkbox"/> Chronic Cough (786.2)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Other   | <input type="checkbox"/> Chronic Sinusitis (473.9)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> General Fatigue (780.7)   | <input type="checkbox"/> Irregular Menstrual Flow (626.4)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Profuse Menstrual Flow (626.7)  | <input type="checkbox"/> Breast Soreness/Lumps (611.72)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Endometriosis (617.9)   | <input type="checkbox"/> PMS (625.4)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Loss of Bladder Control (788.30)  | <input type="checkbox"/> Painful Urination (788.1)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Frequent Urination (788.41)   | <input type="checkbox"/> Abdominal Pain (789.0)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Constipation/Irregular Bowel Habits (564.0)   | <input type="checkbox"/> Heartburn/Indigestion (787.1)   |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |
| <input type="checkbox"/> Dermatitis/Eczema/Rash (692.9)  | <input type="checkbox"/> Depression (311)  |         |  |  |   |  |  |   |   |   |  |                                       |  |   |  |   |  |  |  |  |   |   |   |   |   |  |   |   |  |   |  |   |  |  |   |  |   |      |         |  |   |  |  |   |   |   |  |                                |  |  |   |   |   |  |                                      |   |  |  |   |  |  |   |   |

**If you or a family member has had any of the following, please mark the appropriate box:**

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Epilepsy              |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Chronic Headaches     |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Lupus                 |
| <input type="checkbox"/> Lung Problems        | <input type="checkbox"/> Other Conditions      |
| <input type="checkbox"/> High Blood Pressure  |  |

- | Past   | Present  |
|--|--|
| <input type="checkbox"/> Pregnancy (V22.2)             | <input type="checkbox"/> Birth Control Pills                                     |
| <input type="checkbox"/> Hormonal/Estrogen Replacement | <input type="checkbox"/> Medications (please list) _____                         |
| <input type="checkbox"/> Vitamins/Herbs _____          | <input type="checkbox"/> Hospitalization/Surgical Procedures (please list) _____ |

- |                          |   |
|--------------------------|---|
| Yes                      | No  |
| <input type="checkbox"/> | <input type="checkbox"/> Do you have a permanent disability rating? |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty in Swallowing (787.2)           |
| <input type="checkbox"/> | <input type="checkbox"/> Location _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> Date rating received ____/____/____        |
|                          | Rating Percentage _____%  |

Please check any of the following that apply to you.

- | Past  | Present  |
|---|--|
| <input type="checkbox"/> Liver (573.9) / Gallbladder (575.9) problems | <input type="checkbox"/> Tobacco (305.1)   |
| <input type="checkbox"/> Muscular Incoordination (781.3)              | <input type="checkbox"/> Alcohol (305.0)   |
| <input type="checkbox"/> Kidney Stones (592.0)                        | <input type="checkbox"/> Drug or Alcohol Dependence (303.9)  |
| <input type="checkbox"/> Tinnitus (Ear Noises) (388.30)               | <input type="checkbox"/> Coffee/Tea/Caffeinated Soft Drinks: Cups/Cans per day (please list) Present |
| <input type="checkbox"/> Hepatitis (573.3)                            |  |
| <input type="checkbox"/> Rapid Heart Beat (785.0)                     |  |
| <input type="checkbox"/> Bladder Infection (595.9)                    |  |
| <input type="checkbox"/> Chest Pains (786.50)                         |  |
| <input type="checkbox"/> Kidney Disorders (by condition)              |  |
| <input type="checkbox"/> Loss of Appetite (783.0)                     |  |

Weight: \_\_\_\_\_ pounds Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Doctor's additional comments/general health concerns:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_