Mountain Community Chiropractic Wellness Center
Dr. Tirrell Magnuson

CHIEF Complaints or Symptoms: **Name:** ______________________________

Date: __________

☐ **Neck pain**
check off the areas that the pain runs into from the neck

☐ none ☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand
☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand

☐ headache
☐ Migraine Headache
☐ upper back pain

Ringing in Ears	☐ Yes	☐ No	☐ Left	☐ Right	☐ Both Ears
Blurry Vision	☐ Yes	☐ No	☐ Left	☐ Right	☐ Both Eyes
Wrist Pain	☐ Yes	☐ No	☐ Left	☐ Right	☐ Both Wrists
Jaw Pain	☐ Yes	☐ No	☐ Left	☐ Right	☐ Both Sides

☐ Dizziness ☐ nervousness ☐ fatigue ☐ anxiety ☐ depression ☐ excessive irritability
☐ fear of driving in a car ☐ a loss of concentration ☐ jaw clenching ☐ grinding of teeth at night ☐ nightmares ☐ difficulty with sleeping at night

☐ **Low Back Pain**
select the areas of radiation, if any...

☐ none ☐ buttocks ☐ left buttock ☐ left thigh ☐ left knee
☐ left foot ☐ right buttock ☐ right thigh ☐ right knee ☐ right foot

Hip Pain	☐ Left	☐ Right	☐ Bilateral
Knee Pain	☐ Left	☐ Right	☐ Bilateral
Foot Pain	☐ Left	☐ Right	☐ Bilateral

Numbness:

☐ Left Hand	☐ Left Upper Arm	☐ Right Hand	☐ Right Upper Arm
☐ Left Foot	☐ Left Leg	☐ Right Foot	☐ Right Leg

Additional Symptoms/ Complaints:

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Have You lost any time from work due to your injuries? ☐ Yes ☐ No
If yes please give dates: ______________________________
Type of employment: ______________________________

Dr Signature ______________________________