Present Complaint Form

GCC
GOOING
CHIROPRACTIC
CLINIC
(714) 556-9188
3151 AIRWAY AVE., SUITE P2
COSTA MESA, CA 92626

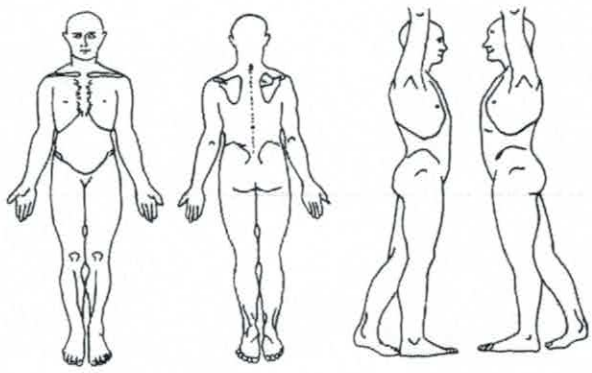
Name_____ **Date**_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

In the space below, please describe the complaint(s), which brought you to this clinic for care. The information you provide concerning past and present symptoms and diseases assists the doctor in obtaining an early understanding of your state of health.

1. Present Complaint:
   _____
   _____
   _____
2. Please describe the character of your current symptoms. (You may check more than one answer.)
   ___ Sharp/Stabbing ___ Sharp/Dull ___ Aches ___ Dull_____ Soreness ___Weakness ___Throbbing/Gnawing
   ___Numbness___Shooting ___Gripping/Constricting ___Burning ___ Tingling
3. How often are the complaints present?
   ___Constant (76—100%) ___Frequent (51-75%) ___Occasional (35-50%) ___Intermittent (25% or less)
4. How bad are your symptoms right now? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
   (0 is no pain) (10 is unbearable)
5. Since your problem began, are the symptoms: ___ Increasing ___ Decreasing ___ Not changing
6. When did your problem begin: Specific date if possible _____
7. Did your problem begin: ___ Immediately after specific incident ___ Multiple incidents ___ Gradually developed over time
8. Describe how your problem began: _____
   _____
9. What treatment have you received for this present condition? ___ Surgery ___ Spinal injections ___ Physical Therapy
   ___ Chiropractic ____ Back Support ___ Nutritional Therapy ____Other_____
10. Any history of auto or motorcycle accidents? ___ yes ___ no
    If yes, please explain. _____
11. What makes your problem better? ___ Nothing ___ Laying down ___ Walking ___ Standing ___ Movement/exercise
    ___ Inactivity ___ Other _____
12. What makes your problem worse? ___ Nothing ___ Laying down ___ Walking ___ Standing ___ Movement/exercise
    ___ Inactivity ___ Other _____
13. Are your complaints affecting your ability to work or otherwise be active? ___ No Effect
    ___ Need limited assistance with common tasks ___ Need assistance often___ Significant inability to function w/o help
    ___ Some physical restrictions ___Totally disabled

Please mark on the picture below.... **SC** for scars - **SU** for surgeries - **P** for Pain - **N** for numbness or tingling



Patient Signature_____ **Date:** _____

Risk Factors and Consent to Examine

GCC
GOOING
CHIROPRACTIC
CLINIC
(714) 556-9188
3151 AIRWAY AVE., SUITE P2
COSTA MESA, CA 92626

As a Doctor of Chiropractic, we use the standard of care procedures and tests to examine you. We also use alternative techniques such as; applied kinesiology, QRA, Neuro Emotional Technique, Erchonia Cold Laser, metal toxicity testing, meridian point testing, EMF/EMR toxicity testing, spinal disc trauma testing, body composition tests, stress testing, rehabilitation and X-ray exams. We may refer you out for more intensive tests if we feel it is necessary in your case.

We need to be informed of any factors that may create a risk or adverse reaction to any of the alternative therapies that we provide or may recommend in your care.

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. The Doctor will evaluate any conditions you have checked for possible contraindication of alternative health care.

RISK FACTORS					
☐	Nasal Surgeries	☐	Osteoporosis	☐	Statin Drugs
☐	Throat surgeries	☐	Osteopenia	☐	Coumadin
☐	Lungs/difficulty breathing/Asthma	☐	Fibromyalgia	☐	Plastic Surgery
☐	COPD	☐	Cluster Headaches	☐	Botox Injections
☐	Parkinson's	☐	Trigeminal Neuralgia	☐	Spinal Surgeries/List
☐	Dementia	☐	Thyroid Problems	☐	
☐	Alzheimer's	☐	Gout	☐	
☐	Spinal Stenosis	☐	Hair Loss	☐	Unusual Blood Test Results
☐	Spondyliolithesis	☐	Hemorrhoids	☐	Sciatic Pain
☐	Strokes	☐	ADHD/ADD	☐	Disc Injury
☐	High Blood Pressure	☐	Autism	☐	Rheumatoid Arthritis
☐	High Cholesterol	☐	Macular degeneration/Glaucoma	☐	Reiter's Syndrome
☐	Metal Implants:	☐	Peripheral Neuropathy	☐	Ankylosing Spondylitis
☐	Stints	☐	Sudden Weakness in Extremities	☐	Psoriatic Arthritis
☐	Teeth	☐	Loss of Urinary Control	☐	Ligamentous Hyper Mobility
☐	Pace Maker	☐	Allergies	☐	Cancer
☐	Extremities	☐	Tremors in Hands	☐	Steroid Drugs/Prednisone

I have completed the health risk survey and consent to an examination by Gooing Chiropractic Clinic. The examination will help the Doctor determine the best options for alternative care given by Gooing Chiropractic Clinic.

Name: _____

Signature: _____ Date: _____