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**ACCIDENTS  
ACHES  
ALLERGIES  
BUMPS  
COLDS  
CONSTIPATION  
FALLS  
FATIGUE  
HEADACHES  
INDIGESTION  
NERVOUSNESS  
PAINS  
SELF-ADMINISTERED TREATMENT  
SLEEPLESSNESS  
STIFFNESS  
STOMACH TROUBLE  
TENSION**

## CHANGE OF CONDITION REPORT

If you have experienced a sudden change in your physical condition, we would like to know about it because we want your treatment to be the best possible for your present state. Your complete recounting of any discomfort you have felt, and any accidents or injuries you have had recently, even if you experienced no apparent reaction, will help us help you more. Please provide us with the information requested below.

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

List any falls, accidents, or other injuries you have had since your last visit: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

Where did it happen? \_\_\_\_\_  
\_\_\_\_\_

What happened? \_\_\_\_\_  
\_\_\_\_\_

List any out-of-the-ordinary pains, discomforts, or other symptoms you have experienced as a result of this injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

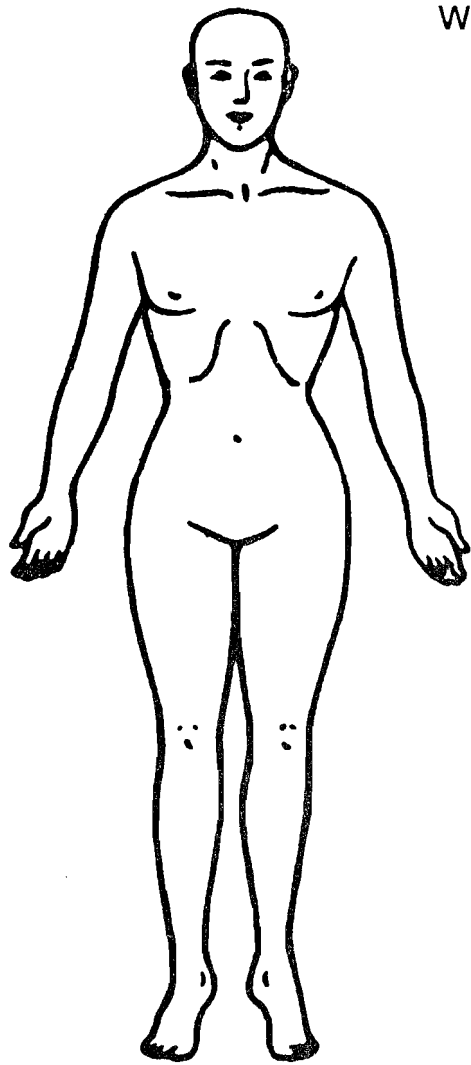
What have you done to try to relieve your symptoms?  
\_\_\_\_\_  
\_\_\_\_\_

Have you received any other medical care for this injury? If so, where and what? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

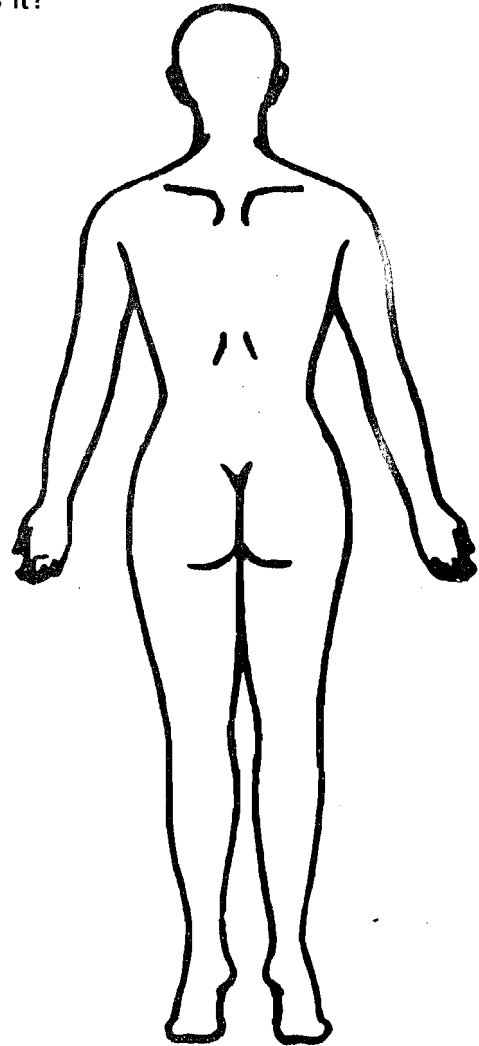
**ALSO COMPLETE OTHER SIDE!**

On the illustrations below, please draw a line from the area of pain or injury to the word which most accurately describes it:



What kind of pain is it?

- Sharp
- Dull
- Tingling
- Numbness
- Constant
- Comes & Goes
- Other



It is worse when I: \_\_\_\_\_

\_\_\_\_\_

Other comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Patient