HEARTLAND FAMILY CHIROPRACTIC, PLLC

1. **What was the mechanism of injury or condition? (Check all that apply)**

	Of unknown origin		After over-arching or reaching
	After a fall		After preforming household chores
	After a long drive		After performing yard work
	After a poor night's sleep		After sitting in one place too long
	After a slip		Associated with prolonged or chronic illness
	After lifting an object		Other:

2. **Activity of daily living most affected? (Check all that apply)**

	Employment		Social Life
	Homemaking		Standing
	Lifting		Traveling and/ or Driving
	Personal care (washing, dressing, etc.)		Walking
	Sitting		Other:
	Sleeping		

3. **What do you have difficulty performing due to this specific complaint? (Check all that apply)**

	Bending over		Making love
	Caring for family		Lying down
	Climbing Stairs		Reaching overhead
	Concentrating		Rising out of chair for bed
	Dressing self		Showering or bathing
	Driving car		Sitting
	Exercising		Standing
	Getting in/ out of car		Staying asleep
	Getting to sleep		Using a computer
	Grocery shopping		Walking
	Preforming household chores		Participating in yard work
	Lifting object		Other:
	Looking over shoulder		

_________________________________ _____________________

Signature Date