Grande Ronde Chiropractic Clinic LLC

Dr. Casey A. McKeown, DC DACBSP
1108 J Avenue
La Grande, OR 97850
PHONE: (541)963-0339
FAX: (541)663-8882
Email: 0001mckeown@gmail.com

Name: **Date:**

Please describe the reason for this visit:

Chief Complaint: ____________________

When did this begin? ____________________

Original Injury Date (if different from above): ____________________

Has this concern occurred before? Yes No

Briefly Explain: ____________________

Have you seen another doctor for this? Yes No
Doctors Name: ____________________ Specialty: ____________________
Type of treatment: ____________________

Was this problem the result of an automobile accident or work related injury? Yes No

Since the onset has this problem: [ ] Gotten Worse [ ] Stayed Constant [ ] Comes and Goes

Does this concern interfere with [ ] Work [ ] Sleep [ ] Daily Routine [ ] Other________________

Briefly Explain: ____________________

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

CIRCLE ONE NUMBER ON EACH LINE

1-Yes limited a lot 2- Yes limited a little 3- No not limited at all

Activity			
• Vigorous activities such as running lifting heavy objects participating in strenuous sports	1	2	3
• Moderate activities such as moving a table pushing a vacuum cleaner bowling or playing golf	1	2	3
• Lifting or carrying groceries	1	2	3
• Climbing several flights of stairs	1	2	3
• Climbing on flight of stairs	1	2	3

CIRCLE ONE NUMBER ON EACH LINE

1-Yes limited a lot **2- Yes limited a little** **3- No not limited at all**

• **Bending kneeling or stooping**	1	2	3
• **Walking more than a mile**	1	2	3
• **Walking several blocks**	1	2	3
• **Walking one block**	1	2	3
• **Bathing or dressing yourself**	1	2	3

Describe the discomfort you are feeling. Just indicate below with a yes or no whether you are currently experiencing any of the following symptoms. If the answer is yes indicate where, the duration, and when this happens. If this happens constantly just write constant.

- **Pins and needles**
- **Fuzzy feeling**
- **Burning sensation**
- **Tingling**
- **Numbness**
- **Aching**
- **Throbbing**
- **Tension**
- **Muscle spasm**
- **Sharp**
- **Deep pain**
- **Other __________________**

Below please rate your current condition on a scale of one to ten (ten being unbearable pain and 1 being almost no pain at all), please rate your current concern.

1 2 3 4 5 6 7 8 9 10

Have you had any radiology reports done for this specific concern? (MRI, CT scan, X-Ray etc….)

Yes No If yes, Where? ____

And finally we need to know your goals for your care.

- **I want the doctor to select the type of care appropriate for my condition**
- **Relief care**
- **Corrective care**
- **Comprehensive care**