Referred by:_____

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Telephone H:_____ Wk:_____ Cell:_____ Driver Lic#_____

Age_____ Birth date_____/_____/_____ Sex M / F Status S M D W No. Children_____ Email_____

Occupation_____ Employer_____ Years Employed_____

Address_____ City_____ State_____ Zip_____

Spouse's Name_____ Occupation_____ Employer_____

Person Responsible for this Account_____ Health Plan_____

Subscriber's Name_____ ID#_____ Group#_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider in understanding your health condition.

Please describe your problem and how it began. Date problem began:_____/_____/_____ _____

_____

_____

How bad is your pain? (Circle a number)	0 No Pain	1	2	3	4	5	6	7	8	9	10 Unbearable Pain

How often are your symptoms present?	☐ Occasionally	☐ Intermittently	☐ Frequently	☐ Constantly
Describe your current pain/symptoms:	☐ Sharp/Stabbing		☐ Throbbing	☐ Aches
	☐ Dull		☐ Soreness	☐ Weakness
	☐ Numbness		☐ Shooting	☐ Gripping
	☐ Burning		☐ Tingling	☐ Other_____
Since it began, is your problem:	☐ Improving		☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing		☐ Lying Down	☐ Walking
	☐ Standing		☐ Sitting	☐ Movement
	☐ Exercise		☐ Inactivity/rest	☐ Other_____
Can you do your daily home activities?	☐ Yes		☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily		☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting		☐ Light Labor	☐ Heavy Labor
Can you do your daily work activities?	☐ Yes, all activities		☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild		☐ Moderate	☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, physical therapy, chiropractic, etc.)

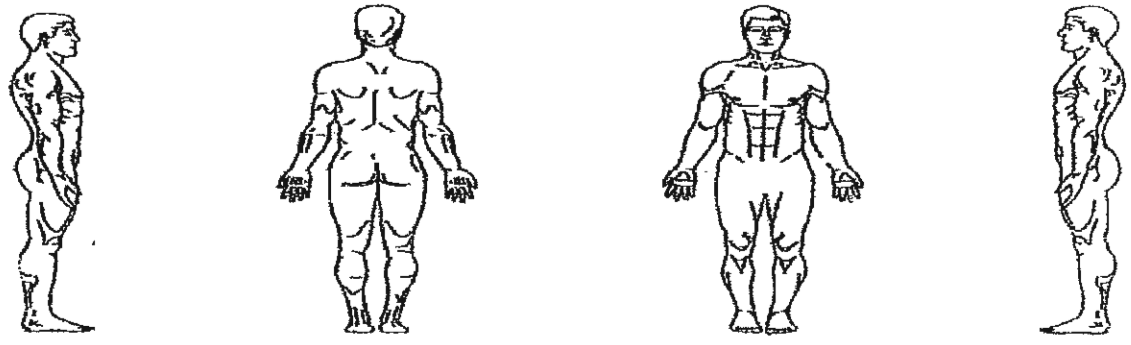
_____

_____

Have you had X-rays, MRI or other tests for this condition? What tests and When?_____

_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature:_____ Date:_____