

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.**

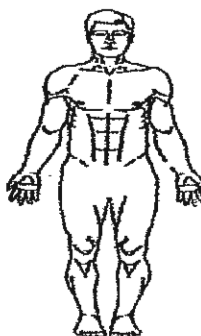
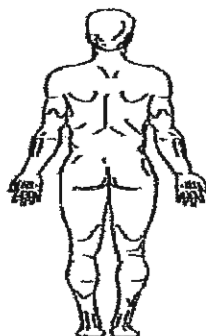
Please describe your problem and how it began. Date problem began: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

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