First_____Last_____
Birthdate_____
Address_____
City _____State _____ Zip_____
Email Address:_____
Primary Care Physician _____
Cell Phone (if you prefer text reminders please leave your cell #)
_____ Home Phone_____
Insurance Company _____
Referred By:_____

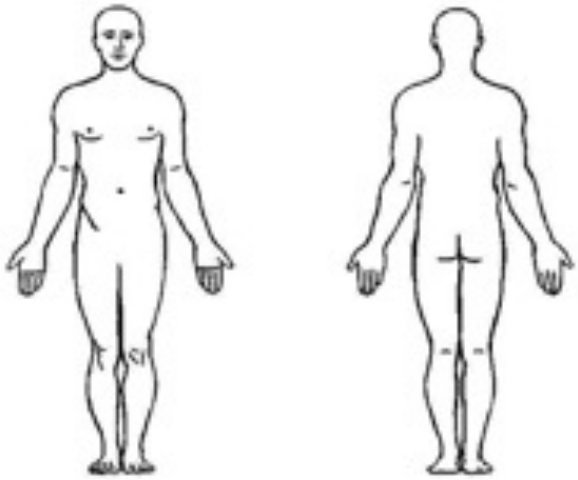
Occupation and Hobbies:_____

Describe your current problem and how it began:

_____

DATE PROBLEM BEGAN:_____
Mark an X on the picture where you have pain or other symptoms:

- ○ Headache
- ○ Neck Pain
- ○ Mid-Back Pain
- ○ Low Back Pain
- ○ Other_____



Are your symptoms due to :

- ○ Work related
- ○ Auto Accident
- ○ Daily Activities
- ○ Sports Injury ○ Other

_____

How often are your symptoms present?
Occasionally 0-25% 26-50% 51-75% 76-100% Constant

How do you feel today?
0 1 2 3 4 5 6 7 8 9 10 / No Pain or Unbearable

In the past week how much has your pain interfered with your daily activities? 0 1 2 3 4 5 6 7 8 9 10

Have you ever had spinal XRays, MRI, CAT scan or other imaging for your area of complaint? _____
Yes____ No _____ Dates Taken_____What Areas? _____WhereTaken_____

In general how would you say your overall health is?
Excellent Very Good Fair Poor

PLEASE CIRCLE ALL THAT APPLY FOR YOUR HEALTH HISTORY:

Alcohol Drug Dependence
Recent Fever
Diabetes: Type:
Blood Clots
Cortiscosteroid Use
Taking Birth Control Pills
Dizziness/Fainting
Numbness in Groin/Buttocks
Cancer/Tumor
Prostate Problems
Menstrual Problems
Urinary Problems
Thyroid: High/Low_____ or removed
Cancer :
Abnormal Weight Loss or Gain
Pain Unrelieved by Position or Rest
Morning Pain or Stiffness
Pain at Night
Tobacco Use: Frequency
Heart Attack/Stroke/ Aneurysm
Gallstones
Kidney or Liver Issues or Hepatitis C
Vertigo

PARENT/ GAURDIAN SIGNATURE:_____
PATIENTSIGNATURE:_____DATE:

Doctor Use:
Chief Complaint :_____
Blood Pressure:_____ **Height:**_____ **Weight:**_____
L_____
O_____
Palliative_____
Provocative_____
Progressive_____
P_____
Q_____
R_____ **S**_____
T_____
Diagnosis:_____
Treatment Plan:_____r