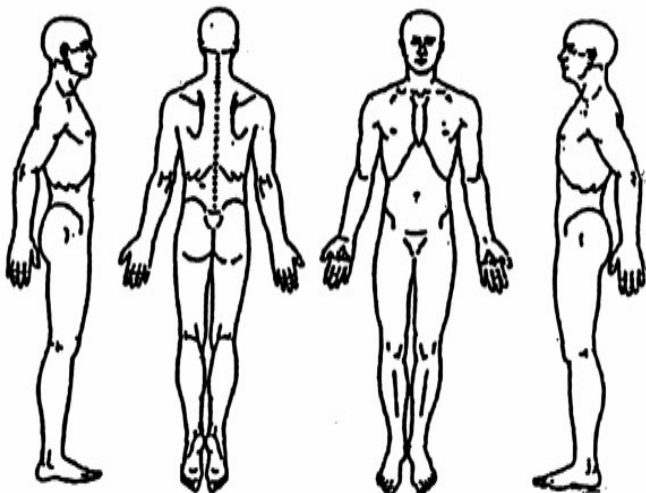


CONFIDENTIAL PATIENT INFORMATION

Patient Name:(First) _____ (M.I) _____ (Last) _____ Date: ____/____/____
 Title: Mr . Mrs. Miss. Ms. Dr Other: _____ Nickname: _____
 Address: _____ City: _____ St. _____ Zip _____
 SS#: ____/____/____ Gender: M F Marital status: S M D W Separated
 Spouse Name: _____ Date of Birth: ____/____/____ Age: ____
 Phone:(Home) _____ (Cell) _____ (Work) _____
 Email _____ Emergency contact: Name: _____
 Relationship: _____ Phone # _____
 Will Payment Be: Self Pay Insurance Medicare

1. Is today's problem caused by: Auto Accident Workman's Compensation Injury

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Occasionally (26-50% of the time)
- Frequently (51-75% of the time)
- Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
- Dull Tingly
- Diffuse Sharp with motion
- Achy Shooting with motion
- Burning Stabbing with motion
- Shooting Electric like with motion
- Stiff Other: _____

5. How are your symptoms changing with time? Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem? Chiropractor Neurologist Primary Care Physician

- ER physician Orthopedist Massage Therapist Physical Therapist No one Other: _____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? Yes Yes, at times No

13. What aggravates your problem? _____

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____ Occupation _____

16. How would you rate your overall Health? Excellent Very Good Good Fair Poor

17. What type of exercise do you do? Strenuous Moderate Light None

