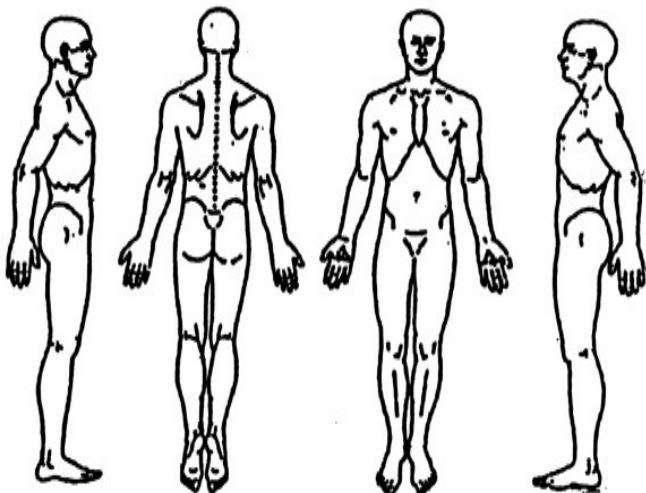


**CONFIDENTIAL PATIENT INFORMATION**

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

**18. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis    
  Diabetes    
  Lupus    
  Heart Problems    
  Cancer    
  ALS

**19. For each of the following conditions, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**For Females Only**  
 Birth Control Pills  
 Hormonal Replacement  
 Pregnancy

**20. List all prescription medications you are currently taking:**

\_\_\_\_\_

**21. List all of the over-the-counter medications you are currently taking:**

\_\_\_\_\_

**22. List all surgical procedures you have had:**

\_\_\_\_\_

**23. What activities do you do at work?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

**24. What activities do you do outside of work?**

\_\_\_\_\_

**25. Have you ever been hospitalized?**      No      Yes     If yes, why \_\_\_\_\_

**26. Have you had significant past Injures / trauma?**      No      Yes     \_\_\_\_\_

**27. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_