



Name: _____ Date: _____ File #: _____ Case Type: _____

Sex: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____
Residence and Mailing City State Zip Code

Home Phone: _____ Mobile Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Marital Status: S M D W Spouse's Name: _____ Spouse's Birth Date: _____

No. of Children: _____ Emergency Contact: _____ Contact Phone: _____

How did you hear about us? _____ Billboard _____ Referral (Please Name) _____
_____ Radio _____ Magazine Ad (Please List) _____
_____ Phone Book _____ Other (Please List) _____

Primary (First) Complaint and Location

Chief Complaint (Reason for Visit): _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

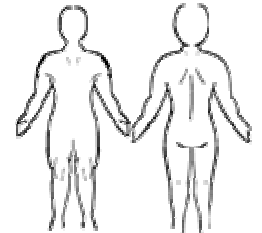
Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

- | | | | | |
|-----------------|----------------|-----------------|------------------------|-----------------|
| _____ Sharp | _____ Shooting | _____ Stiffness | _____ Crawling | _____ Pulsating |
| _____ Dull | _____ Burning | _____ Deadness | _____ Pins and Needles | _____ Prickly |
| _____ Throbbing | _____ Tingling | _____ Stabbing | _____ Stinging | _____ Pounding |
| _____ Aching | _____ Cramping | _____ Numb | _____ Excruciating | |



What makes it worse?

- | | | | | |
|------------------|--------------------------|------------------|---------------------|---------------------------|
| _____ Sitting | _____ Lifting | _____ Driving | _____ Looking Down | _____ Sneezing |
| _____ Standing | _____ Coughing | _____ Walking | _____ Rotating Head | _____ Carrying |
| _____ Bending | _____ Straining | _____ Exercising | _____ Stress | _____ Climbing Stairs |
| _____ Lying Down | _____ Getting out of bed | _____ Looking Up | _____ Bright Lights | _____ Repetitive Movement |

What makes it better?

- | | | | | |
|---------------|---------------|------------------------|------------------|-------------------------|
| _____ Ice | _____ Rest | _____ Pain Medications | _____ Lying Down | _____ Exercising |
| _____ Heat | _____ Tylenol | _____ Mineral Ice | _____ Sleeping | _____ Anti-inflammatory |
| _____ Massage | _____ Advil | _____ Muscle Relaxers | Other: _____ | |

What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Have you seen other doctors for this condition? Yes No If yes, who? (Name) _____

Type of Treatment: _____ Are you satisfied with the results of the treatment? Yes No

Do you exercise? None Infrequent Regular Frequent and Heavy
Sufficient rest Never Rarely Occasionally Moderately
Hours of sleep 3-4 5-6 7-8 9-10 More than 10
Personal stress Low Medium High Very high
Occupational stress Low Medium High Very high
Well balanced diet Never Rarely Occasionally Regularly
Do you smoke? No Occasionally 1 to 5 6 to 10 11-15 Packs per day?
Do you drink alcohol? No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 per day
Do you drink caffeine? No Occasionally 1 to 2 2 to 3 4 to 5 More than 5 per day

Secondary Complaint and Location

Secondary Complaint: _____

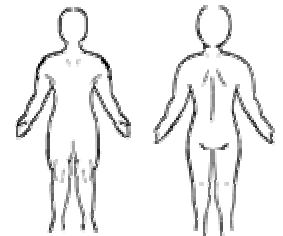
When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____



Please describe your symptoms:

Sharp Shooting Stiffness Crawling Pulsating
 Dull Burning Deadness Pins and Needles Prickly
 Throbbing Tingling Stabbing Stinging Pounding
 Aching Cramping Numb Excruciating

What makes it worse?

Sitting Lifting Driving Looking Down Sneezing
 Standing Coughing Walking Rotating Head Carrying
 Bending Straining Exercising Stress Climbing Stairs
 Lying Down Getting out of bed Looking Up Bright Lights Repetitive Movement

What makes it better?

Ice Rest Pain Medications Lying Down Exercising
 Heat Tylenol Mineral Ice Sleeping Anti-inflammatory
 Massage Advil Muscle Relaxers Other: _____

What time of day is it worse? Morning End of day Night Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: Work Sleep Daily Routine Recreation None

Third Complaint and Location

Third Complaint: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

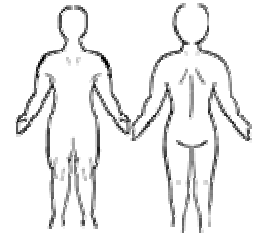
Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

- | | | | | |
|------------------------------------|-----------------------------------|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Crawling | <input type="checkbox"/> Pulsating |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Deadness | <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Prickly |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Stinging | <input type="checkbox"/> Pounding |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Cramping | <input type="checkbox"/> Numb | <input type="checkbox"/> Excruciating | |



What makes it worse?

- | | | | | |
|-------------------------------------|---|-------------------------------------|--|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Looking Down | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Walking | <input type="checkbox"/> Rotating Head | <input type="checkbox"/> Carrying |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Straining | <input type="checkbox"/> Exercising | <input type="checkbox"/> Stress | <input type="checkbox"/> Climbing Stairs |
| <input type="checkbox"/> Lying Down | <input type="checkbox"/> Getting out of bed | <input type="checkbox"/> Looking Up | <input type="checkbox"/> Bright Lights | <input type="checkbox"/> Repetitive Movement |

What makes it better?

- | | | | | |
|----------------------------------|----------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Rest | <input type="checkbox"/> Pain Medications | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Mineral Ice | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Anti-inflammatory |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Advil | <input type="checkbox"/> Muscle Relaxers | Other: _____ | |

What time of day is it worse? Morning End of day Night Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: Work Sleep Daily Routine Recreation None

Past Health History

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Neurological Health History

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Facial Weakness | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Sensation Loss | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Smell Disturbance | <input type="checkbox"/> Stroke | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Speech Disturbance | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |

Musculoskeletal Health History

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abnormal Posture | <input type="checkbox"/> Disc Herniation | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Elbow Problem |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Wrist Problem |
| <input type="checkbox"/> Dislocation/Fracture | <input type="checkbox"/> Shoulder Problem _____ | <input type="checkbox"/> TMJ Syndrome | <input type="checkbox"/> Ankle Problem |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Knee Problem _____ | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pes Planus |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sprain/Strain _____ | <input type="checkbox"/> Tendonitis _____ | Other _____ |

Childhood Illnesses

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Allergies / Hay Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes (Type I)
<input type="checkbox"/> Fetal Drug Exposure	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rash	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Other _____	<input type="checkbox"/> Bed Wetting

Adult Illnesses

<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Anemia	<input type="checkbox"/> CRPS (RSD)	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Crohn's / Colitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes (Type II)	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> STD's (unspecified)
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Lupus Erythema	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Other _____
<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Suicide Attempt(s)	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Ear Infections (frequent)	

Past Surgeries

<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Ceaserian Section	<input type="checkbox"/> Carpal Tunnel Repair
<input type="checkbox"/> Coronary Artery Bypass	<input type="checkbox"/> Cosmetic	<input type="checkbox"/> D & C	<input type="checkbox"/> Rotator Cuff
<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Laminectomy _____	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Pacemaker Insertion	<input type="checkbox"/> Knee Replacement
<input type="checkbox"/> Spinal Fusion _____	<input type="checkbox"/> Tympanostomy	<input type="checkbox"/> Cardiac Catherization	<input type="checkbox"/> Hip Replacement

Current Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins and Supplements

_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Drug Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature (Patient or Guardian)

Date