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Please fill out the form in as much detail as possible:

Name____ Date ______________________________

Address ____________________________ Apt.#_____ City________________ State_____ Zip __________

Phone: Home ______________________ Mobile ______________________Work ____________________

Age______DOB______________SS#______________Sex: M / F Occupation ______________________

Health Insurance ________________________________ PPO / EPO / HMO Referred by ______________

Height______Weight______ E-mail Address _____________________________Marital Status: M / S / D / W

Emergency Contact _________________________ Relationship ______________ Phone ________________

Primary Problem ____

Date of injury/onset ____

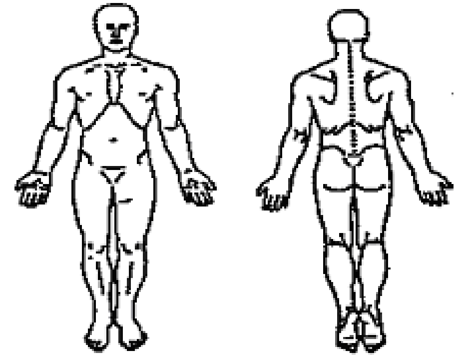
How did it happen? ____

What makes it worse?____

What makes it better?____

Rate your problem: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Is the problem getting worse? No / Yes, Explain ______________________



Describe how the pain feels? (Sharp, Dull, Achy, Shock-Like, Burning, Etc.) ___________________________

Does the problem radiate into the arms/legs? ☐No ☐Yes, Where ___________________________________

At what time of day is the problem worse? ☐Constant ☐Morning ☐Afternoon ☐Evening ☐Night

Have you ever had a similar problem before? ☐No ☐Yes, When? ___________________________________

Are you taking any medication for this problem? ☐No ☐Yes, List ___________________________________

Please check all of the following that apply to you:

No	Yes		No	Yes		No	Yes	
☐	☐	Recent Infection	☐	☐	Headaches	☐	☐	Cancer/Tumor ______________
☐	☐	Recent Fever	☐	☐	Jaw Pain: L / R	☐	☐	Recent Frequent Urination
☐	☐	HIV / AIDS	☐	☐	Neck Pain	☐	☐	Recent Urinary Retention
☐	☐	Diabetes	☐	☐	Upper Back Pain	☐	☐	Birth Control Pills
☐	☐	High Blood Pressure	☐	☐	Lower Back Pain	☐	☐	Pregnancy, # of births ________
☐	☐	Epilepsy / Seizers	☐	☐	Shoulder Pain: L / R	☐	☐	Numbness in the Groin/Buttocks
☐	☐	Dizziness / Fainting	☐	☐	Elbow Pain: L / R	☐	☐	Prostate Problems
☐	☐	Visual Disturbance	☐	☐	Wrist/Hand Pain: L / R	☐	☐	Stroke (Date) _____________
☐	☐	Osteoporosis	☐	☐	Hip Pain: L / R	☐	☐	Alcohol Use ________________
☐	☐	Corticosteroid Use	☐	☐	Knee Pain: L / R	☐	☐	Tobacco Use ________________
☐	☐	Arthritis	☐	☐	Ankle Pain: L / R	☐	☐	Surgeries __________________
☐	☐	Aortic Aneurysm	☐	☐	Foot Pain: L / R	☐	☐	Medications_________________

Family History: ☐Arthritis ☐High Blood Pressure ☐Cancer ☐Diabetes ☐Heart Problems

I certify that the above information is true and accurate. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due and payable.

Patient's Signature ______________________________________ Date ____________________________