



Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: _____ **Social Security #:** _____ **Age:** _____ **Birth date:** ___/___/___

Sex: M / F **Occupation:** _____ **Employer:** _____ **Wk. Ph:** _____ **Cell Ph:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Spouse's Name:** _____

Person Responsible for this Account: _____ **Health Plan:** _____

Subscriber's Name: _____ **ID#:** _____ **Group#:** _____

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)? _____

WHO REFERRED YOU TO THIS CLINIC? _____

PLEASE DESCRIBE YOUR CURRENT PROBLEM. _____

HOW DID YOUR PROBLEM BEGIN? _____

DATE PROBLEM BEGAN: ___/___/___

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION? (surgery, medications, therapy, chiropractic, etc.) _____

HAVE YOU HAD X-RAYS, MRI OR OTHER TESTS FOR THIS CONDITION? WHAT TESTS AND WHEN? _____

How bad is your pain? (Circle the number.)											
0	1	2	3	4	5	6	7	8	9	10	
No pain										Unbearable Pain	

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms. Ache Throbbing Sharp/Stabbing
 Dull Soreness Weakness
 Numbness Shooting Gripping
 Burning Tingling Other _____

Since it began, is your problem: Improving Getting Worse No Change

What makes the problem BETTER? Nothing Lying Down Walking
 Standing Sitting Movement
 Exercise Inactivity / Rest Other _____

What makes the problem WORSE? Nothing Lying Down Walking
 Standing Sitting Movement
 Exercise Inactivity / Rest Other _____

Any effect on home/work activities? Yes Only some Not at all

Do you exercise? Yes Yes, occasionally Not at all

Describe your job requirements: Mainly sitting Light Labor Heavy Labor

Describe your stress level: None to mild Moderate High

Mark an X on the picture where you have pain or other symptoms. Include symptoms of pain, numbness or tingling.

