



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: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

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.

<input type="checkbox"/> Ache	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Sharp/Stabbing
<input type="checkbox"/> Dull	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Gripping
<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Other _____

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

What makes the problem BETTER?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Movement
<input type="checkbox"/> Exercise	<input type="checkbox"/> Inactivity / Rest	<input type="checkbox"/> Other _____

What makes the problem WORSE?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Movement
<input type="checkbox"/> Exercise	<input type="checkbox"/> Inactivity / Rest	<input type="checkbox"/> 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.

