ABOUT YOU

First Name _____ Middle Name _____

Last Name _____ Social Security #: _____-____-_____

Street Address _____APT_____

City _____ State _____ Zip _____

Phone _____-_____-_____ C H W Phone_____-_____-_____ C H W

Email Address_____

Date of Birth ____ / ____ / _____ Gender ⌐ Male ⌐ Female Pregnant YES NO

AGE:_____ Height _____'_____" Weight _____ lbs

Marital Status ⌐ Single ⌐ Married ⌐ Separated ⌐ Divorced ⌐ Widowed ⌐ Other

Patient's Occupation: _____Patient's Employer: _____

Insurance _____Policy#_____

Insurance_____Policy#_____

Number of Children____Spouse DOB:_____Spouse's Name _____

Spouse's Employer_____

EMERGENCY CONTACT INFORMATION

Name _____

Phone _____-_____-_____ Relation to You _____

REFERRAL INFORMATION

Referring Physician _____ Contact Info_____

Are You Working with an Attorney? YES NO

Attorney Name:_____ Phone:____-____-_____

How Did You Hear About Us?

⌐ Insurance ⌐ Advertisement ⌐ Social Media ⌐ Word of Mouth ⌐ Internet

Referring Patient _____

REASON FOR VISIT

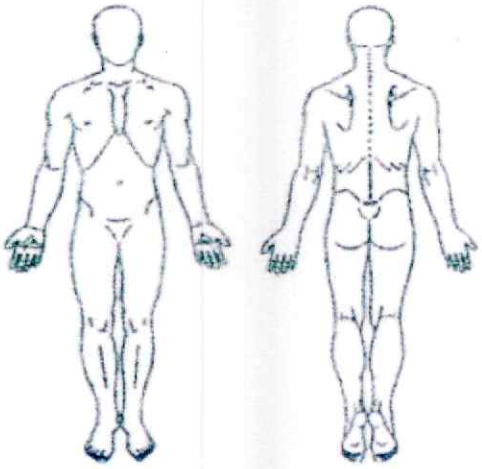
What caused this condition? _____

What is the date this condition began? _____ / _____ / _____

What terms describe your discomfort best? Aching Burning Tingling Sharp other_____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? Constant Frequent Occasional Intermittent

How has this complaint changed since the onset? Worsened Remained the same Improved

What *activity* is difficult due to this discomfort?(i.e: work, golfing, biking**) (Explain)**_____

_____

What aggravates this condition? (i.e.sit, stand, heat, reach, twist)_____

What improves this condition or gives you relief? (ie. ice, heat, sitting, lying) _____

_____

***Who* have you seen for this condition up to now?**_____

What treatment have you received for this condition up to now? _____

Have you ever had any previous episodes of this condition? Yes No

Explain:_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints — No Yes Explain: _____

Nerves, Headaches, Dizziness, or Emotional — No Yes Explain: _____

Head, Eyes, Ears, Nose or Throat — No Yes Explain: _____

Heart, Blood Pressure, or Circulation — No Yes Explain: _____

Shortness of Breath, Coughing, Asthma or Lung Condition — No Yes Explain: _____

Stomach, Bowels or Digestive Conditions — No Yes Explain: _____

Genital, Bladder, or Urinary Conditions — No Yes Explain: _____

Diabetes, Thyroid or Glandular Conditions — No Yes Explain: _____

Skin or Bleeding Conditions — No Yes Explain: _____

Allergies or Sensitivities — No Yes Explain: _____

Have you had any surgical procedures? — No Yes Explain: _____

Are you presently taking any medication? — No Yes Explain: _____

Are there any past illnesses or conditions we should be aware of? — No Yes Explain: _____

Do you have a past history of accidents or trauma — No Yes Explain: _____

_____

Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of: No Yes Explain: _____

_____

Current work habits: select all that apply

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits: select all that apply

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other. to be discussed with doctor

Present exercise habits: select all that apply

- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ Cannot return to exercise due to current condition