Name: _____ **Date:** _____

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

Phone: (H) _____ **(C)** _____ **Email:** _____

(by providing my email address, I authorize my doctor to contact me via the email address provided)

Date of Birth: _____ **Sex: (F) (M) Marital Status: (S) (M) (D) (W)**

Occupation: _____ **Employer:** _____ **Work #** _____

Spouse's Name: _____ **Spouse's Date of Birth:** _____ **Spouse's Employer:** _____

Race (Circle): White Black/African American Hispanic Other:_____ I choose not to specify

Verification Question: (choose only one question by circling the question, then give the answer to that question)

What is the name of your favorite pet?	In what city were you born?	What high school did you attend?
What is your favorite movie?	What is your mother's maiden name?	On what street did you grow up?
What was the make of your first car?	When is your anniversary?	

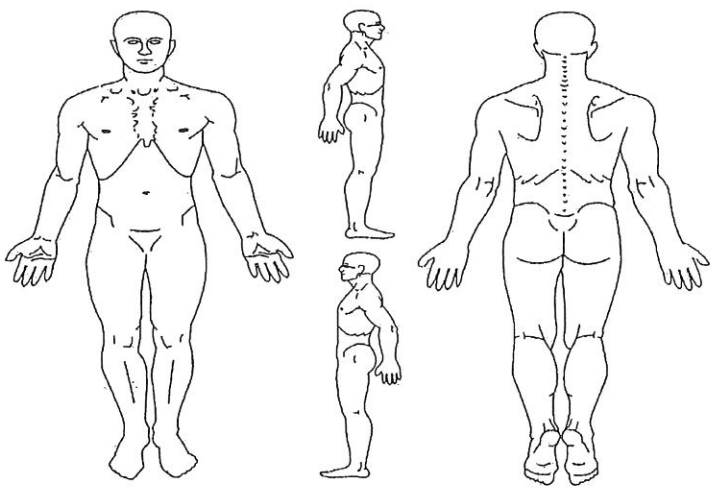
Verification Answer to the Chosen Question: _____

Answers must be at least 6 characters.

How did you hear about our office? _____

What is your primary complaint? _____

Indicate where you have pain or other symptoms?



Please circle how bad it hurts: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most pain)

When did your symptoms begin? Month _____ Day _____ Year _____

What caused your symptoms? ( ) Unknown ( ) Work related accident ( ) Motor vehicle accident

( ) Other _____

How often do you experience your symptoms? Please circle one:

Constant (80%) Frequent (60%) Intermittent (40%) Occasional (20%)

If your pain is not constant, how long d an episode last? _____

My symptoms are:

Worse in the morning Worse throughout the day Worse at night

Does the problem/pain radiate or travel to any other areas in your body? (Y) (N)

If so where? _____

Please describe your complaint: Please circle all that apply:

Dull Sharp Throbbing Burning Deep Aching Tingling Stabbing Cramping Numbness Radiating Stiffness

What makes your problem worse? Please circle.

Sitting Standing Walking Bending Stooping Lifting Sleeping Sneezing Coughing Straining Reaching Twistir
Looking Up Looking Down Movement Rest Lying Supine Driving Typing Scooping House Chores Exercise
Lying Prone Stair Stepping

What makes your problem better? Please circle.

Sitting Standing Lying Knees Bent Up Support No Movement Movement Heat Ice Analgesic Topic Ibuprofen
Medication Rest Stretching/Exercise Adjustments

Other doctors seen for this condition and treatment given:

_____

Family History:

	Diabetes	Heart	Kidney	Cancer/ Type
Mother	( )	( )	( )	_____
Father	( )	( )	( )	_____
Sibling	( )	( )	( )	_____

Exercise

( ) None
( ) Light Activity
( ) Moderate Activity
( ) Very Active

Habits:

( ) Smoking Packs/Day _____
( ) Former smoker
( ) Never Smoker
( ) Caffeine Cups/Day _____
( ) Alcohol Drinks/Day _____

Hospitalizations and Injuries (If any broken bones, which ones):

_____

Surgeries: Circle all that apply to you and put year performed.

Cervical Spine _____ Appendectomy _____ Cardiovascular Procedure _____ Hysterectomy _____

Thoracic Spine _____ Prostate _____ Gall Bladder _____ Urinary-Genital _____

Lumbar Spine _____ Shoulder _____ Knee _____ Carpal Tunnel _____

Hernia _____ GI (Procedure) _____ Joint Replacement (Which one): Hip____ Knee____ Shoulder____

Other Surgeries_____

Are you pregnant?

(Yes) (No) (N/A)