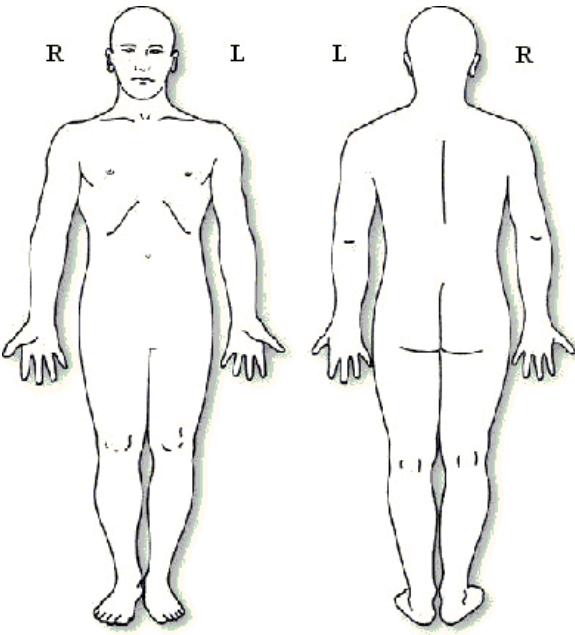


DEMOGRAPHICS:		
Patient Name: _____	DOB: _____	Sex: Male / Female
Occupation: _____	Ht/Wt: _____	Marital Status: _____
Referred by: _____	PCP: _____	Hand Dominance: Right / Left

**REASON FOR VISIT:**

What is the main reason for your visit today: \_\_\_\_\_

\_\_\_\_\_

<p><b>PAIN DIAGRAM: Please indicate areas of pain, numbness, tingling, and/or burning on the following diagram (2 body part limit):</b></p> <p>Pain= P    Numbness= N    Tingling= T    Burning= B</p> <div style="display: flex; justify-content: space-around; margin-bottom: 10px;"> <span>R</span> <span>L</span> <span>L</span> <span>R</span> </div> 	<p><b>SEVERITY: How severe is your pain? (Circle #)</b></p> <table style="width: 100%; text-align: center;"> <tr> <td>0</td> <td>1 2 3</td> <td>4 5 6 7</td> <td>8 9 10</td> </tr> <tr> <td>No Pain</td> <td>Mild</td> <td>Moderate</td> <td>Severe</td> </tr> </table> <p><b>NATURE: Pain is</b></p> <p> <input type="checkbox"/> Occasional    <input type="checkbox"/> Continuous    <input type="checkbox"/> Intermittent  <input type="checkbox"/> Sharp    <input type="checkbox"/> Shooting    <input type="checkbox"/> Aching    <input type="checkbox"/> Dull  <input type="checkbox"/> Improving    <input type="checkbox"/> Worsening    <input type="checkbox"/> Unchanged         </p> <p><b>EFFECT ON DAILY LIFE: Does the condition</b></p> <p>Wake you up at night? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Interfere with work activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Interfere with recreational activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>INCREASING/DECREASING FACTORS:</b></p> <p><b>What makes pain worse?</b></p> <p><input type="checkbox"/> Activity    <input type="checkbox"/> Work    <input type="checkbox"/> Exercise    <input type="checkbox"/> _____</p> <p><b>What makes pain better?</b></p> <p><input type="checkbox"/> Rest    <input type="checkbox"/> Heat    <input type="checkbox"/> Ice    <input type="checkbox"/> _____</p> <p><b>Comments:</b></p> <p>_____</p> <p>_____</p>	0	1 2 3	4 5 6 7	8 9 10	No Pain	Mild	Moderate	Severe
0	1 2 3	4 5 6 7	8 9 10						
No Pain	Mild	Moderate	Severe						

**DETAILS OF THE CURRENT INJURY:**

**How did the injury/symptoms occur?**

Previous injury/recurrence     Gradual onset     Sudden/traumatic     Lifting     Bending     Fall  
 Twisting     Whiplash     Running     Throwing     Other: \_\_\_\_\_

**Where did the injury occur?**

Home     Work     Sports/Recreation     School     Vehicle (MVA)     Other \_\_\_\_\_

**How long have you had these symptoms/injury**

Date of Injury: \_\_\_\_\_ / How long have you had these symptoms \_\_\_\_\_

**THIRD PARTY LIABILITY:**

If this was due to a motor vehicle accident, do you have an accident policy

No  Yes. If Yes please provide details: \_\_\_\_\_

Are you seeking reimbursement from any party or insurance company for the treatment of this injury?

No  Yes. If Yes please provide details: \_\_\_\_\_

Do you have any litigation (legal action/court case) pending for this problem/injury?

No  Yes. If Yes please provide details: \_\_\_\_\_

**DIAGNOSTIC TESTS:**

Please check box and list date if you had any of the following tests performed for this problem:

Xray \_\_\_\_\_

MRI \_\_\_\_\_

CT Scan \_\_\_\_\_

Ultrasound \_\_\_\_\_

Myelogram \_\_\_\_\_

EMG \_\_\_\_\_

Other \_\_\_\_\_

**TREATMENT HISTORY:**

Please check box and list date if you have tried any of the following treatments for this injury/symptoms:

Cortisone injection \_\_\_\_\_

Epidural injection \_\_\_\_\_

OTC pain medication \_\_\_\_\_

Surgery \_\_\_\_\_

Physical Therapy \_\_\_\_\_

Chiropractor \_\_\_\_\_

Walker/crutch/wheelchair  Brace

**CURRENT MEDICATIONS:**

Please list name, dosage of any medications you are taking currently including prescription, over the counter, herbals:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**ALLERGIES:**

Please list any/all drug and food allergies:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**ADDITIONAL INFORMATION:**

If you have had any previous medical care for this issue please list

Treating Dr \_\_\_\_\_  Facility \_\_\_\_\_  Date \_\_\_\_\_

Treating Dr \_\_\_\_\_  Facility \_\_\_\_\_  Date \_\_\_\_\_

Additional comments: \_\_\_\_\_

I certify that to the best of my knowledge, all information listed above is true. I further certify that I have not falsified or intentionally omitted any information related to my health or past medical history.

Signature of patient/guardian: \_\_\_\_\_ Date: \_\_\_\_\_