Name: _____ Date: _____

New Address, if changed: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

New Insurance, if changed: _____

Have you had any surgeries since the last visit? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

List all your prescription medicine _____

Is your complaint direct result from an accident? ☐ Yes ☐ No

What is your complaint today? _____

_____

How did it start? _____

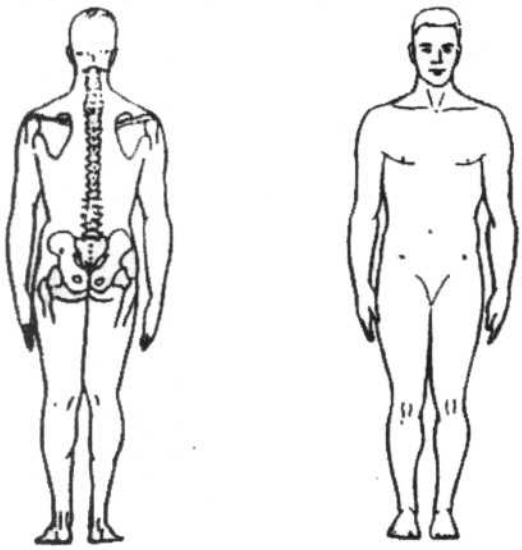
_____

When did it start? _____

Have you seen any other health care provider for the same or similar conditions since the last visit?

☐ Yes ☐ No If yes, _____

Please mark the exact location of your pain on the diagram below.



How often do you experience your symptoms?

☐ Constantly (76-100% of the day)

☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day)

☐ Intermittently (0-25% of the day)

What is the nature of your symptoms?

☐ Sharp ☐ Dull Ache

☐ Numb ☐ Shooting

☐ Burning ☐ Tingling

How are your symptoms changing?

☐ Getting Better

☐ Not changing

☐ Getting worse

***Patient Signature*** _____ ***Date*** _____

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Doctor's Note:

Radiation:

Relief:

Aggravating: