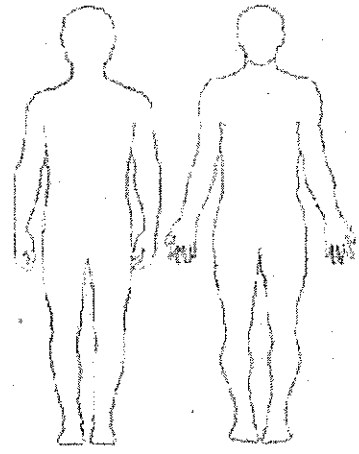
Patient Name: _____ Weight _____ Height _____

Describe Your Current Problem and How It Began: _____

_____

_____



How often are your symptoms present?
☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:
☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?
☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much has your pain interfered with your daily activities?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_____ What areas where taken?_____

Please check all of the following that apply to you:

☐ Recent Fever Numbness (location)
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (date)_____
☐ Dizziness/Fainting
☐ Cancer/Tumor (explain)_____
_____
☐ Osteoporosis
☐ Other Health Problems_____
_____

☐ Numbness
☐ Urinary Problems
☐ Currently Pregnant, # weeks
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries _____
_____
_____
☐ Current Medications _____
_____

Who have you seen for your condition before today?
☐ No One ☐ Medical Doctor ☐ Massage Therapist ☐ Other _____
☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist

What treatment did you receive and when?_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information in not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify the provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient Signature_____Date_____