

NAME: _____ DATE: _____

1. What are we seeing you for today? _____
2. Have you had x-rays of this area? _____ If yes, what facility? _____
3. Is this an injury? Yes No If yes, date of injury _____
If yes, where did injury occur? Please be specific _____

4. Describe how injury or onset of symptoms occurred. Please be specific _____

5. Use the appropriate symbols to mark areas we are seeing you for today

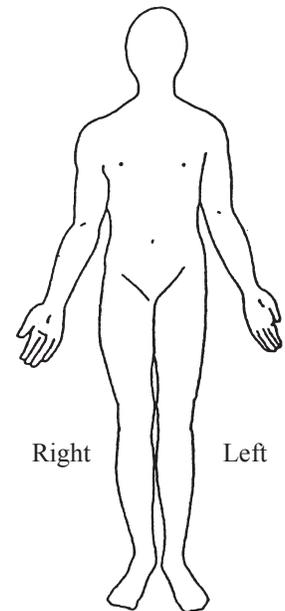
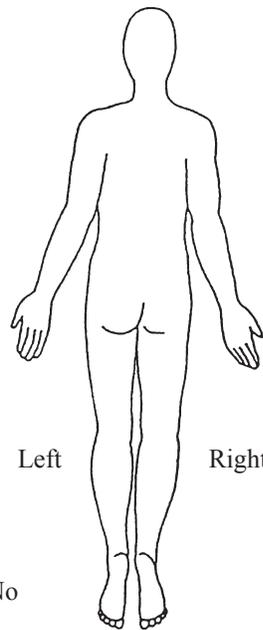
NUMBNESS . . . PINS & NEEDLES ooo
BURNING xxx STABBING ///

ACHE ***
On a scale from 1-10, rate your pain.
1-slight - 10-unbearable _____

Does your pain limit how far you can walk?
Yes _____ No _____
If yes, how far can you walk before the pain
makes you stop? _____

Does your pain limit how long you can sit?
Yes _____ No _____
If yes, how long can you sit before the pain
makes you get out of a chair? _____

Are you currently under a lot of stress?
Yes _____ No _____



6. Have you had a previous injury to this area? Yes No
If yes, please explain _____

7. Have you missed work due to this problem? Yes No How many days? _____
Your job title _____

8. Is there legal action pending related to your problem? Yes No
If yes, attorney's name _____

9. Have you been treated by another healthcare provider for this problem? Yes No
If yes, name of provider(s) _____

10. Please check any treatments or tests you have had for this problem prior to today's visit.
 Chiropractic Injections Surgery Physical Therapy MRI CT Scan Bone Scan
 Nerve Conduction Test Lab tests Where was the service provided? _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT INFORMATION