



# PATIENT INFORMATION

PLEASE COMPLETE THIS FORM COMPLETELY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex F \_\_\_ M \_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

### MEDICAL HISTORY:

• What is the problem you are here for \_\_\_\_\_

• Date of injury or when pain started: \_\_\_\_\_ • Date of Surgery (if applicable): \_\_\_\_\_

#### Check which apply to your injury:

- Work-related
- Athletic / recreational injury
- Recurrence of previous injury
- Cause unknown
- Motor vehicle accident
- Injury related to lifting or falling
- Other: \_\_\_\_\_

• Is this the first time you have had this pain? Y N If NO, then when: \_\_\_\_\_

• What treatments have you tried?  Medications  Physical Therapy  Massage  Chiropractic  Injection

• What Tests/Procedures have been done for your current condition:

X-Rays  MRI/CT Scan  Bone Scan  EMG  Blood Work  Other \_\_\_\_\_

• Do you have any **allergies**? Y N If yes, please list \_\_\_\_\_

• Are you presently taking any **medication**? Y N If yes, please list what medication and for what condition \_\_\_\_\_

### SOCIAL HISTORY:

• Do you Smoke? Y N • Drink Alcohol? Y N • Married? Y N • Children? N Y # \_\_\_ • Do you regularly exercise? Y N

### PAIN AND SYMPTOMS:

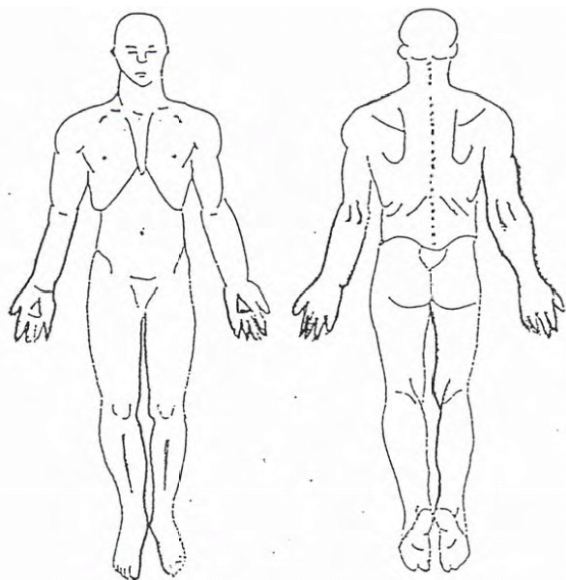
#### Circle the answer:

- Is your pain? Continuous Frequent Occasional
- When is your pain the worst? Morning Afternoon Evening Nighttime
- When is your pain the best? Morning Afternoon Evening Nighttime

**Please check the answers that apply to you:**

- What makes your pain **better**? sitting  sleeping  walking  laying flat  bending forward  bending backward  standing in one place  other: \_\_\_\_\_
- What makes your pain **worse**?  sitting  sleeping  walking  laying flat  driving  bending forward/backward  reaching above your head  walking up/down stairs  other: \_\_\_\_\_

**Please indicate below where your symptoms are located:**



- Circle the number that rates **your pain right now**:  
None 1 2 3 4 5 6 7 8 9 10 Go to the hospital
- Circle the number that rates **your pain at worst**:  
None 1 2 3 4 5 6 7 8 9 10 Go to the hospital
- Circle the number that rates **your pain at best**:  
None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

KEY	
NUMBNESS	++++++
PINS & NEEDLES	000000
BURNING PAIN	XXXXX
STABBING PAIN	//////////
ACHE	!!!!!!!!!!

Please check "yes" if you have ever been diagnosed with...

Auto-Immune Disease	YES	NO	Neurologic	YES	NO
Systemic Arthritis (RA, Lupus, Other)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained rashes, sores or swelling	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia/ Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	YES	NO	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Poor balance with frequent falls	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Recent tremors or clumsy walking	<input type="checkbox"/>	<input type="checkbox"/>
History DVT (Blood Clots)	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling both hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	YES	NO	Currently pregnant (or think you might be)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Vision or hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/Bladder abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Do you have metal implants	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional symptoms (Current)	YES	NO
Heart rate restrictions w/ exercise (per MD)	<input type="checkbox"/>	<input type="checkbox"/>	Fever/ chills/ nights sweats	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Metabolic	YES	NO	Severe fatigue/malaise	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic	YES	NO	Unexplained weight loss, >10% body weight	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Pain at night	<input type="checkbox"/>	<input type="checkbox"/>

Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist

- If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history and recent hospitalizations.

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Patient/Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_