PATIENT INFORMATION

Name____

First MI Last

Address ____

City___________________ **State**_________ **Zip Code**___________

Birth Date_______/_____/__________ **Sex:** Male Female **S/S**______-______-______

Month Day Year

Are you: Minor Married Divorced Single Widowed Separated **Race**:______________

Home Phone #________-________-________ **Cell Phone** #________-________-________

Work #________-________-________

Your Employer________________________**Occupation**_________________**Average Hours /Week**_____

Spouse / Parent / Emergency Name______________________________ **Work Activity**: Sedentary

(Circle one of the above) Moderately Active

Phone # ________-________-________ Highly Active

Employer____

Whom may we thank for referring you to us? ____

SYMPTOMS

LIST AREA OF PAIN **CIRCLE ONE** **RATE PAIN**

#1__________________Left/Right Constant Intermittent 1 2 3 4 5 6 7 8 9 10

What makes pain worse? (circle) All Movement, Bending, Lifting, Walking, Sitting_________________

When did the pain start? ___Days___Weeks___Months___Years **Start?** Gradually or All of a Sudden

What caused the pain to start? Please Explain____

____

Is anything helpful for the pain? Heat Ice Rest Pain Relievers Exercise Other:_____________

Is your sleep affected? Hard to fall asleep or Pain wakes me

Does the pain affect your work? Please Explain____

Doctors who have treated you for <u>THIS</u> issue: ____

Circle the treatment you've had for <u>THIS</u> issue: X-rays-MRI-Medication-Surgery-Physical Therapy-Chiropractic Care

#2__________________Left/Right Constant Intermittent 1 2 3 4 5 6 7 8 9 10

What makes pain worse? (circle) All Movement, Bending, Lifting, Walking, Sitting_________________

#3__________________Left/Right Constant Intermittent 1 2 3 4 5 6 7 8 9 10

What makes pain worse? (circle) All Movement, Bending, Lifting, Walking, Sitting_________________

Patient Signature____**Date**_____/_____/_____