



Patient Information

SS # _____

Last Name _____ First Name _____

Address _____

E-mail _____

City _____ State _____ Zip _____

Sex: Male _____ Female _____

Birthdate _____ / _____ / _____

Height _____ Weight _____

Home Phone _____ Cell Phone _____

Married Widowed Single Minor Separated

Divorced Partnered

Employer / School _____

If Employed, Occupation _____

Work Address _____

Work Phone _____

Spouse Name _____

Spouse Birthdate _____ / _____ / _____

Spouse SS# _____ - _____ - _____

Spouse Employer _____

Whom may we thank for referring you? _____

Home Phone _____ Cell Phone _____

Best Time / Number to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Check Any Allergies

Animal Aspirin Bees Chocolate Dairy

Dust Eggs Latex Molds Penicillin

Rubber Rubber Shellfish Soaps Wheat

Ragweed / Pollen Seasonal Allergies X-Ray Dye

Other _____

List All Surgeries

Back Date _____

Brain Date _____

Shoulder Date _____

Neck Date _____

Knee Date _____

Hip Date _____

Wrist Date _____

Other Date _____

Accident Information / Worker's Comp

Is condition due to an accident? YES NO Date _____

Type of accident: AUTO WORK HOME OTHER

To whom have you made a report of your accident?

Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable) _____

Patient Condition

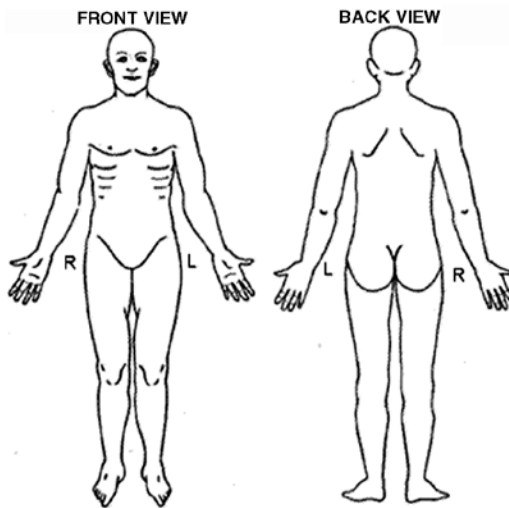
Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? YES NO UNKNOWN

Mark an X on the picture below where you continue to have pain, numbness, or tingling. Then circle the number which best indicates the severity of your pain on a scale from 1 (least) to 10 (sever):

1 2 3 4 5 6 7 8 9 10



Type of Pain:

- ____ Sharp
- ____ Dull
- ____ Throbbing
- ____ Numbness
- ____ Aching
- ____ Burning
- ____ Shooting
- ____ Tingling
- ____ Cramps
- ____ Stiffness
- ____ Swelling
- ____ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Check activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down Turning

Family History: Mother, Father, Grandparents, Sister, or Brother

Arthritis Who _____

Asthma Who _____

Back Problem Who _____

Cancer Who _____

High Blood Pres. Who _____

Diabetes Who _____

Heart Attack Who _____

Stroke Who _____

Depression Who _____



Health Information

Place mark on YES or NO to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Place mark on all which apply:

Exercise	Work Activity	Habits	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/ Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____

Are you pregnant? YES NO Due Date _____

Medications: please list all you are currently taking

Product	Dosage	(Mg) milligrams
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name _____ Pharmacy Phone Number _____