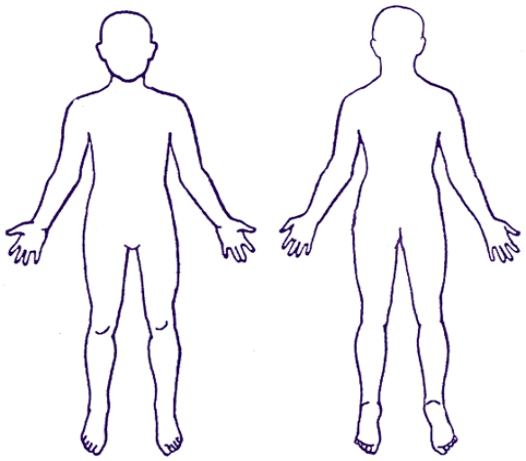
Patient Condition

Reason for this visit: _____

When did symptoms appeared: ___/___/_____ Time: _____ Are they getting worse? No Yes Don't know

On the diagrams to the right, mark the location(s) where the pain/numbness/tingling is located:



Circle word(s) describing your pain/numbness/tingling:

Mild Moderate Severe Sharp Dull Shooting

Burning Tingling Stiff Continual Intermittent

Other (explain:)_____

_____

_____

Does it interfere with: Work Sleep Daily Routine Recreation Sitting Standing Walking Bending Lying Down

What treatment have you already received: _____

_____

Where: _____

By Whom? _____

Patient History (please circle answers and fill blanks)

1. Do you have any Allergies: NO YES

Please list: _____

2. Do you suffer from Headaches: NO YES

If YES, please circle: Frontal Temporal Migrane Sinus After reading Periodic

3. Do you have Respiratory Problems: NO YES

If YES, please circle: Emphysema Asthma Tuberculosis Shortness of breath Cough

4. Do you have any Circulatory Problems: NO YES

If YES, please circle: Blood pressure Stroke Heart attack or angina Murmur Irregular beat

Cold extremeties Blood thinners Pacemaker/defibrillator Other

Explain: _____

_____

_____

5. Have you now, or have you had any dis-function of your Kidneys, Stomach, Liver or Gallbladder? NO YES

If YES, please explain: _____

_____

_____

6. Hormonal Problems: NO YES

If YES, please circle which and explain: Thyroid Diabetes Other – please explain:

_____

Patient History (continued)

7. Are you on Birth Control: NO YES

What method/product? _____

8. Skeletal/Muscular Problems: NO YES

Arthritis Joint pain Muscle disease Orthopedic/Neurological Surgery Osteoporosis

Curvature Scoliosis Fracture Other defect: _____

Fractures – list and how treated: _____

List surgeries: _____

List pins/rods/screws/plates/other implants: _____

Location(s)/date(s) of implants: _____

9. Have you ever had an x-ray, CT scan, or MRI? NO YES

If YES, for what reason(s)? _____

Was Lab Work done in conjunction with the x-ray, CT scan, or MRI? NO YES

If YES, list abnormal findings: _____

10. Have you ever been diagnosed with Degeneration of Bony Tissues? NO YES

11. Has a health care provider ever advised you against a procedure? NO YES

If YES, explain: _____

_____

12. List any other Medical Procedure(s) or Physical Therapy(s) you have had along with the date:

_____

_____

13. List any good result(s) from a procedure/therapy: _____

14. List any bad result(s) from a procedure/therapy: _____

Have you now, or have you had nerve pain and/or numbness? NO YES

If YES, explain: _____

_____

15. Have you now, or have you had a medical condition you would like to discuss with the doctor?

NO YES If YES, explain: _____

_____

16. List all medications/drugs you are taking: _____

17. Are you pregnant? NO YES

18. Can you smile, frown, wink either eye? NO YES

19. Do any health problems run in your family? NO YES

If YES, explain: _____

_____

20. Is there anything additional you would like to discuss with the doctor? NO YES

If YES, explain: _____

_____