Name

Address

City, State, Zip

Email Address

Birthday Date | Last 4 SSN

Occupation/Employer

How did you hear about us?

Emergency Contact

Age | Gender: M F

Phone

Appointment Reminders? Yes No

Martial Status: S M D W P

How many Hours at a Desk Daily? _____

How Many Hours on Your Feet Daily? _____

Phone

What would you like addressed today/Current Complaints:

Is This Visit Related To:

□ Work Injury □ Car Collision

□ At Home Injury □ Gradual Onset

□ Non-Injury Symptoms

□ Other :

Please describe and rate your pain on a scale of 1-10, with 10 being the worst.

Neck: Best____/10 Worst: ____/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	Stiff

How Often is Pain:
Intermittent (0-25%)
Occasional (26-50%)
Frequent (51-75%)
Constant (76-100%)

Pain Is:
Central
Right
Left

Headaches/Migraines: ___/10

How Frequent do they occur?
1x/mon 1-4x/mon 1+/week

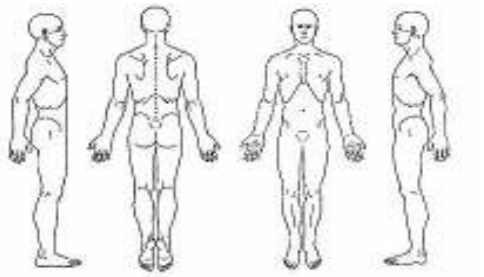
How Long do they last?
0-2 hrs 2-4 hrs 4+ hrs

Described as:
Mild Moderate Severe

Do you take Medication for Pain?
Yes No

List Meds:

Please mark where you experience pain:



Mid-Back: Best____/10 Worst: ____/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	Stiff

How Often is Pain:
Intermittent (0-25%)
Occasional (26-50%)
Frequent (51-75%)
Constant (76-100%)

Pain Is:
Central
Right
Left

Low Back: Best____/10 Worst: ____/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	Stiff

How Often is Pain:
Intermittent (0-25%)
Occasional (26-50%)
Frequent (51-75%)
Constant (76-100%)

Pain Is:
Central
Right
Left

Medication

Are you currently taking:
□ Anti-inflammatory
□ Pain Relievers
□ Muscle Relaxers

How Frequently are you taking meds?
1-4x/Day 1x/week 1x/mon

Has this changed since last visit?
More Less Same

Time of Day Pain is Worse:	□ Morning	□ Afternoon	□ Evening	
	□ Constant	□ Varies with Activities		
Relieving Factors	□ Ice	□ Heat	□ Medication	□ Lying Down
	□ Massage	□ Chiropractic	□ Rest	□ Movement
Aggravating Factors	□ Bending	□ Sitting	□ Standing	□ Lifting
	□ Walking	□ Exercise	□ Lying Down	
	□ Driving	□ Computer/Tech Time		

How does your pain/condition affect your daily activities? Rate how difficult each task is on a scale of 3-10 (with 10 being unable to perform).

□ Limitations at work	3 4 5 6 7 8 9 10
□ Difficulty getting comfortable	3 4 5 6 7 8 9 10
□ Difficulty changing postions	3 4 5 6 7 8 9 10
□ Interrupted Sleep	3 4 5 6 7 8 9 10
□ Limitations during exercise/hobbies	3 4 5 6 7 8 9 10
□ Effected moods/emotions	3 4 5 6 7 8 9 10
Other:	3 4 5 6 7 8 9 10

Medical Information:

□ Allergies to Oils/Lotions/Foods □ Pregnant
□ High/Low Blood Pressure
□ Heart Condition
□ Contact Lenses
□ Infectious Disease □ Other:
□ Broken Bones
□ Scoliosis
□ Bursitis
□ Skin Condition
□ Varicose Veins
□ Arthritis
□ Cancer
□ Seizure/Epilepsy
□ Diabetes
□ Stroke
□ Migraine

Patient Signature:

Today's Date