*PATIENT INFORMATION AND HISTORY/ DATE:*_____

First Name:_____ Last Name:_____

Address: _____ City: _____State: _____Zip: _____

Date of Birth: _____ Social Security Number_____ ___-_____-_____

Phone (H):_____Work:_____Cell:_____

Martial Status: M S W D Have you been to another Dr. for this problem:_____Dr.'s Name_____

Spouse's Name:_____Spouse's Date of Birth:_____

Your Occupation:_____Your Employee:_____

Insurance Company:_____ Policy Number:_____

How where you referred to our office:_____

Email Address:_____

HISTORY OF PRESENT ILLNESS

Chief Complaint/purpose of this appointment:_____
Date symptoms apperared:_____Did it begin _____Gradual _____Sudden _____ Progressive over time
What makes the symptoms increase:_____
What relieves the symptoms:_____
Type of pain_____ Sharp _____ Dull _____Ache _____Burn_____ Throb _____
Does the pain radiate into your _____Arm _____Leg _____ Does not radiate
Do you experience Numbness or Tingling:_____Yes_____No Pain Intensity:____No Pain____Unbearable Pain
How often do you experience these symptoms: _____100%_____75%_____50%_____25%_____10%
NO SYMPTOMS_____EXTREME SYMPTOMS

Is this due to: Auto_____Work_____Other_____ Have you ever had the same or similar condition:_____

If yes, when and describe:_____

Please list all previous treatments for this condition:
Name of treating Physicican:_____Type of Treatment:_____

Drugs Prescribed:_____

Please list all past surgeries:

- Type_____When _____Doctor_____
- Type_____When _____Doctor _____
- Type_____When _____ Doctor _____

Please list all previous accidents and falls:

- What _____When_____
- What_____When _____

Please list any medications or vitamins you are currently taking:

_____ _____ _____

WOMEN ONLY: Are you pregnant_____Yes _____No Any possibility you may be pregnant?____Yes _____No