*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