

Patient Name _____ Subscriber ID # _____ Date _____

Patient Address _____

City _____ State _____ ZIP _____

Primary Language _____ What is your occupation? _____

Describe Your Current Problem and How It Began _____

Onset date _____

Indicate below where you have pain or other symptoms

Is this? Work Related Auto Related N/A

How often are your symptoms present?

0-25% of the day 26-50% of the day 51-75% of the day

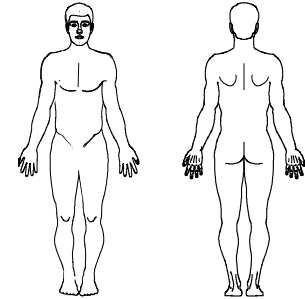
76-100% of the day

Describe the nature of your pain:

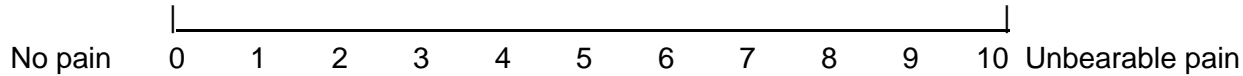
Sharp Dull Ache Numb Shooting Burning Tingling

How is your condition changing?

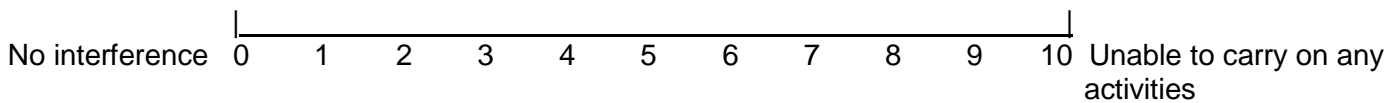
Getting Better Not Changing Getting Worse



Current complaint (how you feel today):



In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



In general would you say your overall health right now is:

Excellent Very Good Good Fair Poor

Please check all of the following that apply to you:

- Recent Fever
- Diabetes
- High Blood Pressure
- Cardiac Condition
- Stroke (date) _____
- Dizziness/Fainting
- Cancer/Tumor (explain) _____
- Osteoporosis
- Other Health Problems (explain) _____
- Numbness (location) _____
- Urinary Problems
- Currently Pregnant, # weeks _____
- Abnormal Weight Gain Loss
- Pain Unrelieved by Position or Rest
- Pain at Night
- Surgeries _____
- Current Medications _____

Who have you seen for your condition before today?

No One Medical Doctor Practitioner for Therapeutic Massage Services Chiropractor
 Physical Therapist Acupuncturist Other _____

What treatment did you receive and when? _____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this practitioner may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my practitioner to contact my physician, if necessary.

Patient Signature _____ Date _____