Patient Information

Name: ____Gender: M / F

Date of birth: ____ / ____ / ____

Address: ____

City: ____________________________________ State: _______ Zip: ___________

Please fill in all phone #s where you can be reached and **mark which one is the best**

Cell: (_____) ______ - _________Home: (______) ______ - _________

Work: (______) ______ - _________

Email: ____

Occupation: ____

Main Duties of your occupation: ____

____

Primary Care Physician: ____

Who referred you to us? ____

Emergency contact: ____

Relationship: ____

Phone: (______) ______ - _________

Have you had x-rays, MRI's , or CT Scans? ( ) Yes ( ) No
If yes, when and what areas:

____

____

____

Surgeries:

____

____

____

Medications and what they are prescribed for:

____

____

____

____

Please check all of the following that apply to you:

- Recent Infection
- Recent fever
- HIV / AIDS
- Diabetes
- Corticosteroid Use
- Birth Control Pills
- High Blood Pressure
- Stroke (date: __________)
- Dizziness / Fainting
- Numbness in groin/ buttocks
- Urinary Retention
- Aortic Aneurysm
- Cancer / Tumor
- Osteoporosis
- Recent Trauma
- Prostrate Problems
- Frequent Urination
- Pregnancy (# of births ____)
- Abnormal Weight ( ) Gain ( ) Loss
- Epilepsy / Seizures
- Visual Disturbances
- History of Low/Mid Back Pain
- Arthritis
- History of Alcohol Use
- History of Tobacco Use

Family History:

( ) Cancer
( ) Diabetes
( ) High Blood Pressure
( ) Cardiovascular Problems / Stroke

Do you wear orthotics? _________ If yes for how long? _______________.
If you wear othotics, what was your reason for getting them ___________
____
____
____.

Please continue on next page

Please describe your current problem and when it began:

____

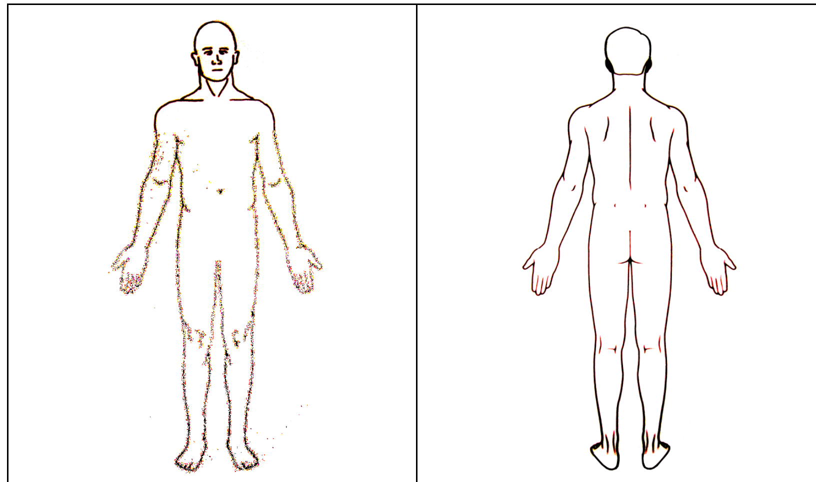
____

____

How do you feel today?

0	1	2	3	4	5	6	7	8	9	10
No pain										Unbearable pain

Please circle areas on the body with pain and indicate the level of the pain with a number (see rating system above).



How often are your symptoms present: ( ) 0-25% ( ) 26-50% ( ) 51-75% ( ) 76-100%

Can you perform your daily activities? ( ) Yes ( ) No Please describe:

____

____

Can you describe activities or movements that make you feel worse?

____

____

Can you describe activities that make you feel better?

____

____

I certify that the above information is complete and accurate. I understand that I am liable for all charges for services rendered and that my insurance coverage may not include such services. I understand that my provider may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my provider to contact my physician, if necessary.

Signature: ______________________________ Date: ____ / ____ / ____