# Patient Form

Name_______________________________

Address______________________City______________State________Zip___________

Phone (H or W)______________(C)______________Network: Verizon, AT&T, ____________

Email Address______________________________Appt. Reminders: Email Text None

O M O F Date of Birth__________Occupation/Employer______________ SS#__________

Married—Y or N If Yes, Spouses name, please______________Referred By:______________

**Describe your symptoms**___________________________________________

______________________________**Symptoms Began On:** | | | |

**How did your symptoms begin?**_______________________________________

How often do you experience your symptoms?

- O Constantly (76-100% of the day)
- O Frequently (51-75% of the day)
- O Occasionally (26-50% of the day)
- O Intermittently (0-25% of the day)

Average pain intensity:

Last 24 hours: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)
Past Week: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

How much has the symptoms interfered with your normal work?

O All of the time O Most of the time O Some of the time O A little of the time O None/ NA

How has your symptoms interfered with your normal activities of daily living?

O Not at all O A little bit O Moderately O Quite a bit O Extremely

How is your current condition/episode changing, since care began at this facility?

O N/A - This is the initial visit O Getting worse O Not changing O Getting better

In general, would you say your overall health right now is…

O Excellent O Very Good O Good O Fair O Poor

**Indicate where you have pain or other symptoms:**

R L L R

**Outcome Assessment Index**

| | |
|---|---|
| Neck Index | |
| Back Index | |
| Quick DASH | |
| Lower Extremity Functional Scale | |

List any surgeries with dates or new medications_______________________________

Patient/Legal Guardian Signature__________________________Date______________