New Patient/Update Information:

Name: ____

First Name *Middle Initial* *Last Name*

□ **Male** □ **Female** **Date of Birth**_____/_____/_____ **Sign in, Pin #** ___-___-___-___

Marital Status: □ Single □ Married □ Other **Social Security #:**_____-_____-_______

Spouse / Parent or Guardian:____

Mailing Address: ____

Address *City* *State* *Zip Code*

Phone: (   ) (   ) (   )

Home Number *Cell Number* *Work Number*

Email Address:____

Employment Information:

Status: □ Employed □ Full Time Student □ Part Time Student □ Other

Employer/School: ____

Name of Employer/School

Occupation: ____

Mailing Address: ____

Address *City* *State* *Zip Code*

Insurance Information: *(we will need a copy of your insurance card(s))* □ Cash Payment

Policy Information: ____

Insured Information (card holder):

Relationship to Insured: □ Self □ Child □ Spouse □ Other

□ **Male** □ **Female** **Date of Birth**_____/_____/_____

Name: ____

First Name *Middle Initial* *Last Name*

Mailing Address: ____

Address *City* *State* *Zip Code*

Employer: ____

Name: ____ ***Date***: ___/____/____

Reason for today's visit:

□ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness

Onset Date: _____/_____/_____

Rate your pain on a scale of 0-10 (10 being the highest): 0 1 2 3 4 5 6 7 8 9 10

How did your injury happen Please explain: ____

____

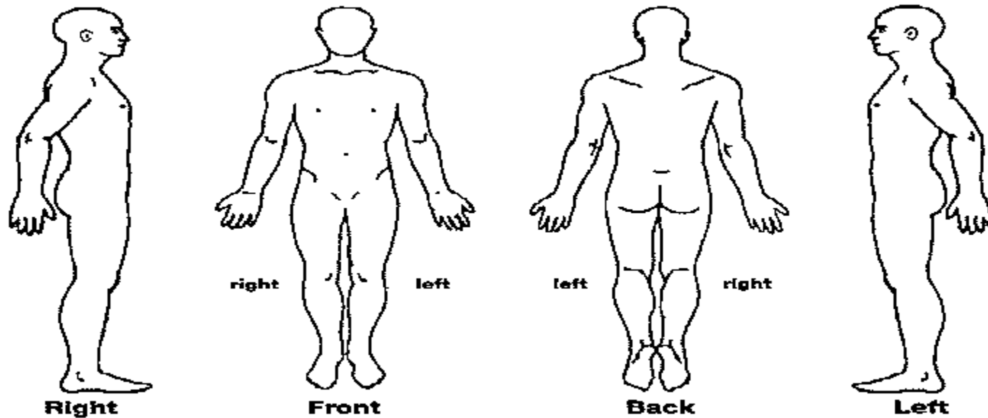
Is your condition worsening? □ Yes □ No □ Constant □ Comes and Goes

If yes, please explain: ____

____

Using the adjacent body chart, identify where you are experiencing the following symptoms:

#: Numbness
X: Burning
/: Stabbing
0: Pins & Needles
+: Dull Ache



Known allergies:____

Do you take supplement vitamins? □ Yes □ No

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No

Has any doctor diagnosed you with High Blood Pressure? □ Yes □ No

Do you have a Pacemaker? □ Yes □ No

Women: **Are you pregnant?** □ Yes, ______ weeks pregnant □ No

Height______________ Weight________________ B/P____________________